CHANGES FOR
OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
ALL HOSPITALS	5,419	9.9	-3.8	-0.4
NON-TEFRA HOSPITALS	4,864	10.0	-3.7	-0.4
NON-TEFRA HOSPITALS: LOCATION				
GEOGRAPHIC LOCATION				
URBAN HOSPITALS	2,677	9.3	-3.3	-0.3
LARGE URBAN AREAS	1,516	9.1	-5.0	-0.5
OTHER URBAN AREAS	1,161	9.6	-0.9	-0.1
RURAL HOSPITALS	2,187	14.7	-5.2	-0.8
BED SIZE (URBAN)				
0- 99 BEDS	654	15.5	-7.4	-1.1
100-199 BEDS	917	10.4	-2.5	-0.3
200-299 BEDS	542	9.2	-0.7	-0.1
300-499 BEDS	425	8.6	-3.3	-0.3
500 OR MORE BEDS	139	8.3	-7.0	-0.6
BED SIZE (RURAL)				
0- 49 BEDS	1,149	19.6	-9.8	-1.9
50- 99 BEDS	644	15.5	-6.9	-1.1
100-149 BEDS	229	13.5	-4.6	-0.6
150-199 BEDS	91	13.0	-2.0	-0.3
200 OR MORE BEDS	74	11.4	0.1	0.0
VOLUME (URBAN)				
0- 4,999 UNITS	278	12.1	-15.6	-1.9
5,000- 10,999 UNITS	442	9.8	-6.3	-0.6

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
11,000- 20,999 UNITS	599	9.1	-5.8	-0.5
21,000- 42,999 UNITS	780	8.7	-3.6	-0.3
43,000 OR MORE UNITS	578	9.7	-2.0	-0.2
VOLUME (RURAL)				
0- 4,999 UNITS	816	18.2	-17.0	-3.1
5,000- 10,999 UNITS	694	15.8	-10.0	-1.6
11,000- 20,999 UNITS	420	14.6	-5.8	-0.8
21,000- 42,999 UNITS	215	13.5	-1.8	-0.2
43,000 OR MORE UNITS	42	13.2	5.3	0.7
URBAN BY CENSUS DIV.				
NEW ENGLAND	152	10.7	-4.9	-0.5
MIDDLE ATLANTIC	399	8.3	-11.3	-0.9
SOUTH ATLANTIC	400	8.6	-3.8	-0.3
EAST NORTH CENTRAL	451	10.7	-0.5	-0.1
EAST SOUTH CENTRAL	158	7.9	0.9	0.1
WEST NORTH CENTRAL	189	9.5	-1.6	-0.2
WEST SOUTH CENTRAL	340	9.7	-2.2	-0.2
MOUNTAIN	122	10.2	1.3	0.1
PACIFIC	429	9.3	0.1	0.0
PUERTO RICO	37	6.8	8.3	8.6
RURAL BY CENSUS DIV.				
NEW ENGLAND	56	16.9	-13.6	-2.3
MIDDLE ATLANTIC	81	13.5	-1.9	-0.3
SOUTH ATLANTIC	283	11.8	-5.7	-0.7
EAST NORTH CENTRAL	288	15.8	-3.3	-0.5
EAST SOUTH CENTRAL	267	11.2	-5.6	-0.6

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
WEST NORTH CENTRAL	516	19.6	-7.7	-1.5
WEST SOUTH CENTRAL	339	14.1	-6.1	-0.9
MOUNTAIN	216	16.7	-3.5	-0.6
PACIFIC	137	16.4	0.8	0.1
PUERTO RICO	4	6.6	34.6	2.3
TEACHING STATUS				
NON-TEACHING	3,847	11.2	-3.1	-0.3
FEWER THAN 100 RESIDENTS	766	9.1	-1.8	-0.2
100 OR MORE RESIDENTS	250	9.2	-9.4	-0.9
DISPROPORTIONATE SHARE PATIENT RATIO				
0	25	25.1	-0.3	-0.1
0.001- 0.099	916	10.3	-4.9	-0.5
0.100- 0.159	1,016	10.9	-0.9	-0.1
0.160- 0.229	977	10.2	-2.9	-0.3
0.230- 0.349	966	9.6	-4.2	-0.4
0.350 AND GREATER	964	9.2	-6.8	-0.6
URBAN TEACHING AND DSH				
BOTH TEACHING AND DSH	957	9.0	-4.6	-0.4
TEACHING AND NO DSH	2	19.8	-18.6	-3.7
NO TEACHING AND DSH	1,708	9.8	-1.9	-0.2
NO TEACHING AND NO DSH	10	28.6	40.8	11.7
RURAL HOSPITAL TYPES				
NONSPECIAL STATUS HOSPITALS	950	15.0	-6.6	-1.0
RRC	168	12.4	-1.9	-0.2
SCH/EACH	625	16.4	-6.7	-1.1

	Number of hospitals (1)	Outpatient percent (2)	Percent change in Medicare outpatient payments (3)	Percent change in total Medicare payments (4)
MDH	365	18.2	-8.5	-1.5
SCH/EACH AND RRC	55	13.7	-2.1	-0.3
TYPE OF OWNERSHIP				
VOLUNTARY	2,877	9.9	-4.0	-0.4
PROPRIETARY	680	7.9	-1.1	-0.1
GOVERNMENT	1,307	12.3	-4.0	-0.5
SPECIALTY HOSPITALS				
EYE AND EAR	13	33.6	1.4	0.5
TRAUMA	160	9.1	-5.9	-0.5
CANCER	10	22.0	-29.2	-6.4
TEFRA HOSPITALS:				
REHABILITATION	141	3.7	-24.1	-0.9
PSYCHIATRIC	304	10.4	-11.7	-1.2
LONG-TERM CARE	70	3.5	-4.1	-0.1
CHILDREN'S	40	9.9	-34.8	-3.4

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XI. Delay in Implementation Date

Like other public and private organizations that depend upon the smooth functioning of computer systems, the Medicare program faces the challenge making changes to assure that computers can recognize dates in the year 2000 and later. Computer programming, which has commonly employed only two digits to record the year in the date for transactions and other entries, will not be able to distinguish the year 2000 from the year 1900 without reprogramming. Such confusion in the context of Medicare enrollment and claims processing could create massive errors, as computers could mistakenly determine that beneficiaries are not eligible for benefits or that services were rendered before the effective date of benefit provisions.

For Medicare, achieving year 2000 (Y2K) compliance involves renovating all computer and information systems. The year 2000 especially affects HCFA because of our extensive reliance on multiple computer systems. More than 183 systems are used in administering the Medicare and Medicaid programs, and 98 of these are considered ''mission critical'' for establishing beneficiary eligibility and making payments to providers, plans, and states. Medicare is the most automated health care payer in the country. The Medicare program processes nearly one billion claims each year, or about 17 million transactions each week. Fully 98 percent of inpatient hospital and other Medicare Part A claims are processed electronically, as are 85 percent of physician and other Medicare Part B claims.

The renovation process is complicated because each piece in the systems used by Medicare, its 60-plus claims processing contractors, interfaces with state Medicaid programs, and some 1.6 million providers must be thoroughly reviewed and renovated by those responsible for each particular system. Programs must be tested, both alone and for the complicated interfaces among them. To fix only the Medicare systems, 49 million lines of code must be renovated. All Medicare-specific software must be renovated, and tested to assure that it continues to work with new versions of vendor-supplied software, including operating systems that drive the hardware. Some hardware must be upgraded, and our telecommunications equipment and software must be compliant. We must assure that all data exchanges with thousands of partners are compliant. Testing of year 2000 changes presents a far greater burden than testing of routine system changes because we must test multiple times on a range of different dates. For example, February 29, 2000 and March 1, 2000 must both be tested because CY 2000 is a leap year.

Because this process is necessary to keep program payments going out to beneficiaries and providers, year 2000 work must take precedence over other projects that require systems changes, including some Balanced Budget Act provisions. The Y2K project must be completed before other projects simply because activity on these other projects would divert resources from the Y2K project and could even compromise the effort to assure Y2K compliance if implemented in tandem. Many other private and public organizations, including most major insurance companies, have reached the same conclusion and are halting other projects involving information technology changes to clear the decks for the year 2000.

HCFA's independent year 2000 verification and validation contractor, Intermetrics, has advised the agency to delay all projects that could interfere with year 2000 work. Intermetrics specifically advised the agency to ''seek necessary relief from Congressional mandates, system transitions and version releases to allow near-term, focused attention to achieving Y2K compliant systems.'' This includes projects that are complex, or which would occur during a critical window between October 1999 and March 2000. Otherwise, they warned, ''many of your most critical system renovations have risk of significant schedule slippage.''

Implementation of outpatient PPS is one of the projects that must be delayed by the year 2000 system renovations, because it requires massive system changes. Major contractor systems will be affected: the Fiscal Intermediary Standard Systems (FISS), the Arkansas Part A Standard System (APASS), the Common Working File (CWF), the Outpatient Code Editor (OCE), and the various systems operated by Fiscal Intermediaries and their corporate entities. Several HCFA systems will also be affected, including the National Claims History (NCH), the Provider Statistical & Reimbursement System (PS&R), and the Electronic Data Interchange (EDI). The scope of the required changes is also substantial. Among the required changes are:

- Expansion of the claim record of FISS, APASS, EDI, NCH and CWF to accept and retain specific information related to how a service is being paid or why it's denied.
- Conversion of all claims history to correspond with expanded format.
- Rewriting the program for FISS to process claims using line item dates of service.
- Rewriting the program for CWF to accept non covered charges by claim and line item.
- Developing, installing and testing an outpatient PRICER which determines payment amounts based on the HCFA Common Procedural Codes (HCPCS).
- Revision of interfaces with the fiscal intermediaries, providers, Billing Agents, EDI, OCE, PS&R and NCH and create an interface for PRICER.
- Developing, installing and testing a program to calculate the variable co-insurance per payment code grouping for each provider who elects to accept a reduced co-insurance.
- Revision of all claims processing output and interfaces including: Medicare Summary Notices (MSN), Beneficiary Denial Letters (BDL), Explanation of Medicare Benefits (EOMB), Notice of Utilization (NOU), Remittance Advice (RA).

The consequence of all these required changes to basic systems will be to change the entire way Fiscal Intermediaries process and pay hospital outpatient and community mental health center claims. There is also a major impact on the many systems that are required to receive this revised output. Changes of this magnitude require massive testing by all of the systems maintainers as well as each Fiscal Intermediary. Additionally, the impact on the Fiscal Intermediary systems has a domino effect. The intermediaries are doing business for Medicare under the auspices of their respective corporate entities. These corporate systems must be modified to accept, edit and relay the new information necessary to process outpatient PPS claims. They are also working toward becoming millennium compliant and competing for the same resources to scope, program, test and rework these changes, as well as the multitude of other BBA changes and Y2K. In the light of this, HCFA has no choice but to suspend implementing such massive change while the Intermediaries, their respective corporate entities, the standard systems maintainers as well as the provider community are working diligently to become Y2K compliant. It would be irresponsible to continue activity that would create a real danger that basic enrollment and claims processing activities will be disrupted, with far worse consequences for providers and beneficiaries than delay in implementation of outpatient PPS will cause.

We analyzed whether existing systems could be used to mimic processing of bills under the outpatient PPS. In every case, there were insuperable obstacles. In no case, for example, could these other systems compute the coinsurance correctly: the other available systems compute coinsurance as 20 percent of charges or 20 percent of a fee schedule amount. We have therefore reluctantly concluded that there is no alternative to a delay in implementation. As previously noted, the outpatient PPS will be implemented as soon as possible after January 1, 2000. A notice of the anticipated implementation date will be published in the **Federal Register** at least 90 days in advance.

We expect that there will be no negative impact on hospitals generally from the delay in implementation. The effect on individual hospitals will, of course, vary depending on how their current cost-based reimbursement compares to the total payments they would receive under the proposed system. Hospitals altogether should receive about the same level of Medicare program payments under the existing payment system, as they would have received in program payments under the outpatient PPS. When beneficiary coinsurance is taken into account, we expect that hospitals generally will receive about 3.8 percent more in total payments under the existing payment system, than they would have received in total payments under the outpatient PPS. We should note that payment rates will be established at the level they would have been if the PPS had been implemented on January 1, 1999.

The major impact of the delay in implementation will be on beneficiaries who will continue to pay coinsurance based on 20 percent of the hospital's charges. In the aggregate, we estimate beneficiary coinsurance would have been 6.9 percent lower under the outpatient prospective payment system in 1999 than under the current system. Under the prospective payment system, coinsurance will be based on our estimate of the median coinsurance amount for each APC under the current system in 1999. In the aggregate, estimated median coinsurance amounts are 6.9 percent lower than estimated mean coinsurance amounts for each APC. The actual impact will depend on the extent to which hospitals raise their charges in 1999. For example, the impact on beneficiaries would be moderated if hospitals show restraint in increasing charges (which have been increasing more rapidly than cost). We will actively encourage hospitals to voluntarily restrain from increasing their current charges. The actual impact on a given beneficiary will also depend on the hospital's charge structure relative to national charge levels. A beneficiary receiving services from a hospital with relatively low charges could be advantaged by the delay whereas a hospital with relatively high charges would be disadvantaged by the delay. We note that the impact will not be carried over to the prospective payment system.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Health facilities, Hospitals, Medicare.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 1003

Administrative practice and procedure, Archives and records, grant program—social programs, Maternal and Child Health, Medicaid, Medicare, Penalties.

For the reasons set forth in the preamble, 42 CFR chapters IV and V would be amended as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

A. Part 409 is amended as set forth below:

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

2. In § 409.10, paragraph (b) is revised to read as follows:

§ 409.10 Included services.

* * * * *

(b) *Inpatient hospital services* does not include the following types of services:

(1) Post-hospital SNF care, as described in § 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.

(2) Nursing facility services, described in § 440.155 of this chapter, that may be furnished as a Medicaid service under title XIX of the Act in a swing-bed hospital that has an approval to furnish nursing facility services.

(3) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(6) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(7) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(8) Services of an anesthetist, as defined in § 410.69 of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Part 410 is amended as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)), unless otherwise indicated.

Subpart A—General Provisions

2. In § 410.2, the following definitions are added in alphabetical order to read as follows:

§ 410.2 Definitions.

As used in this part—

* * * * *

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

* * * * *

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

* * * * *

Subpart B—Medical and Other Health Services

3. In § 410.27, the section heading is revised, the introductory text to paragraph (a) is revised, the introductory text to paragraph (a)(1) is republished, and new paragraphs (a)(1)(iii), (e), and (f) are added to read as follows:

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if—

(1) They are furnished—

* * * * *

(iii) In the hospital or at a location (other than an RHC or an FQHC) that HCFA designates as qualifying as a department of a provider under § 413.65 of this chapter; and

* * * * *

(e) Services furnished by an entity other than the hospital are subject to the limitations specified in § 410.39(a).

(f) Services furnished at a location (other than an RHC or an FQHC) that HCFA designates as having provider-based status under § 413.65 of this chapter must be under the direct supervision of a physician as defined in § 410.32(b)(3)(ii).

4. In § 410.28, paragraph (a)(4) is removed, paragraph (c) is redesignated as paragraph (d), and new paragraphs (c) and (e) are added to read as follows:

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

* * * * *

(c) Diagnostic services furnished by an entity other than the hospital or CAH are subject to the limitations specified in § 410.39(a).

* * * * *

(e) Medicare Part B makes payment under section 1833(t) of the Act for diagnostic tests performed at a facility (other than an RHC or an FQHC) that HCFA designates as having provider-based status only when the diagnostic tests are furnished under the appropriate level of physician supervision specified by HCFA in accordance with the definitions in § 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii).

5. A new § 410.39 is added to read as follows:

§ 410.39 Limitations on coverage of certain services furnished to hospital outpatients.

(a) Except as provided in paragraph (c) of this section, Medicare Part B does not pay for any item or service that is furnished to a hospital outpatient (as defined in § 410.2) during an encounter (as defined in § 410.2) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to its patients.

(b) As used in paragraph (a) of this section, the term ''hospital'' includes a CAH.

(c) The limitations stated in paragraphs (a) and (b) of this section do not apply to the following services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

C. Part 411 is amended as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart A—General Exclusions and Exclusion of Particular Services

2. In § 411.15, the introductory text is republished; the section heading to paragraph (m) is revised; paragraph (m)(1) is revised; the introductory text to paragraph (m)(2) is republished; paragraphs (m)(2)(iii), (m)(2)(iv), and (m)(2)(v) are redesignated as paragraphs (m)(2)(iv), (m)(2)(v), and (m)(2)(vi), respectively; and new paragraphs (m)(2)(iii) and (m)(3) are added to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

(m) *Services to hospital patients*—(1) *Basic rule.* Except as provided in paragraph (m)(2) of this section, any service furnished to an inpatient of a hospital or to a hospital outpatient (as defined in § 410.2 of this chapter) during an encounter (as defined in § 410.2 of this chapter) by an entity other than the hospital, unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the hospital's patients. (As used in this paragraph (m)(1), the term ''hospital'' includes a CAH.)

(2) *Exceptions.* The following services are not excluded from coverage:

* * * * *

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

(3) *Scope of exclusion.* Services subject to exclusion under the provisions of this paragraph (m) include, but are not limited to, clinical laboratory services; pacemakers and other prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses); artificial limbs, knees, and hips; equipment and supplies covered under the prosthetic device benefits; and services incident to a physician service.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

D. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. In § 412.50, paragraphs (a) and (b) are revised to read as follows:

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10

of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) HCFA does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

E. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart A—Introduction and General Rules

§ 413.1 [Amended]

2. In § 413.1, paragraph (a)(2)(viii) is removed.

Subpart B—Accounting Records and Reports

3. In § 413.24, the heading to paragraph (d) is published, and a new paragraph (d)(6) is added to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Management contracts.* (i) If the main provider purchases services for a department of the provider or a provider-based entity through a management contract or otherwise directly assigns costs to the department or entity, the like costs of the main provider must be carved out to ensure that they are not allocated to the department of the provider or provider-based entity. However, if the like costs of the main provider cannot be separately identified, the costs of the services purchased through a management contract must be included in the main provider's administrative and general costs and allocated among the provider's overall statistics.

(ii) Costs of free-standing entities may not be shown in the provider's trial balance for purposes of stepping down overhead costs to such entities. The provider must develop detailed work papers showing the exact cost of the services (including overhead) provided to or by the free-standing entity and show those carved out costs as non-reimbursable cost centers in the provider's trial balance.

* * * * *

Subpart E—Payments to Providers

4. A new § 413.65 is added to read as follows:

§ 413.65 Requirements for a determination that a facility or an organization is a department of a provider or a provider-based entity.

(a) *Definitions.* In this subpart E, unless the context indicates otherwise—

Department of a provider means a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider may not be licensed to provide health care services in its own right, and Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term ''department of a provider'' does not include an RHC or an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC or an FQHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, that complies with the provisions of this section.

(b) *Responsibility for obtaining provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) A provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider begins billing for services of the facility or organization as if they were furnished by a department of the provider or provider-based entity, or before it includes costs of those services on its cost report.

(3) A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility, unless it is determined by HCFA to have provider-based status.

(c) *Reporting.* (1) A main provider that acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to HCFA and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status.

(2) A main provider that has had one or more facilities or organizations considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

(d) *Requirements.* An entity must meet the following requirements to be determined by HCFA to be a provider-based entity or a department of a provider:

(1) *Licensure.* The department of the provider and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of

the provider. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, HCFA will determine that the facility or organization does not have provider-based status.

(2) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the facility or organization.

(3) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the provider where it is located.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a day-to-day reporting relationship with a manager at the main provider; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider's billing department.

(4) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a day-to-day reporting relationship with the Chief Medical Officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(5) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of the facility or organization are reported in a cost center of the provider, and the financial status of the facility or organization is incorporated and readily identified in the main provider's trial balance.

(6) *Public awareness.* The facility or organization seeking status as a department of a provider is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except where the following requirements are met:

(i) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, either by submitting records such as common patient lists and/or demographic data showing that a high percentage of patients of both the main provider and the applicant entity come from the same geographic area, or by submitting data substantiating that the patients served by the entity also receive services from the main provider (for example, the patients of an RHC receive inpatient hospital services from the main provider).

(ii) A facility or organization is not considered to be in the ''immediate vicinity'' of the main provider if the facility or organization and the main provider are located in different States.

(e) *Provider-based status not applicable to joint ventures.* A facility or organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created free-standing facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the free-standing facility as a provider-based entity.

(f) *Management contracts.* Facilities and organizations operated under management contracts are considered provider-based if all of the following criteria are met:

(1) The staff of the facility or organization are employed by the

provider or by another organization other than the management company.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (b)(3)(iii) of this section.

(3) The main provider has significant day-to-day control over the operations of the facility or organization as determined under criteria in paragraph (b)(3)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(g) *Obligations of hospital outpatient departments and hospital-based entities.* (1) Hospital outpatient departments located either on or off the main premises of the hospital must comply with the anti-dumping rules in §§ 489.20(l), (m), (q), and (r) and 489.24 of this chapter. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus, and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24, the hospital must comply with the anti-dumping rules in § 489.24.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied.

(3) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(4) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provisions in § 489.10(b) of this chapter.

(5) Hospital outpatient departments (other than RHCs) must hold themselves out to other payers as outpatient departments of that hospital, and must treat all patients, for billing purposes, as hospital outpatients. The department must not treat some patients as hospital outpatients and others as physician office patients.

(6) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at § 412.2(c)(5) of this chapter and at § 413.40(c)(2), respectively.

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC), the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the beneficiary's potential financial liability (that is, a coinsurance liability for an outpatient visit to the hospital as well as for the physician service).

(8) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

(9) A facility or organization may not qualify for provider-based status if all services furnished at the facility are furnished under arrangement.

(h) *Inappropriate treatment of a facility or organization as provider-based.* If HCFA learns of a provider treating a facility or organization as provider-based without notifying HCFA to obtain a determination of provider-based status, HCFA reconsiders all payments to that provider for all cost reporting periods subject to re-opening in accordance with §§ 405.1885 and 405.1889 of this chapter. HCFA then investigates and determines whether the requirements in paragraph (d) of this section were met. If the facility or organization did not qualify for a provider-based determination, HCFA recovers the difference between the amount of payments that actually were made and the amount of payments that should have been made in the absence of a determination of provider-based status, except that recovery will not be made for any period prior to [insert the effective date of final rule] if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (i)(2) of this section.

(i) *Inappropriate billing.* (1) If HCFA determines that a provider has been inappropriately billing Medicare for services furnished in a physician office or other facility or organization as if they had been furnished in a hospital outpatient department or other department of a provider or in a provider-based entity, HCFA stops all payments to the provider for outpatient services until the provider can demonstrate which payments are proper. If overpayments have been made, HCFA recovers the difference between the amount of payments that actually were made and the amount of the payments that should have been made in the absence of the determination of provider-based status. However, past payments attributable to treatment as a department of a provider or a provider-based entity for any period prior to [insert effective date of final rule] are not recovered if during all of that period the management of a facility or an organization made a good faith effort to operate it as a department of a provider or a provider-based entity, as described in paragraph (i)(2) of this section, prior to [insert effective date of final rule].

(2) HCFA determines that the management of a facility has made a good faith effort to operate it as a provider-based entity if—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) of this section are met;

(ii) All facility services were billed as if they had been furnished by a department of a provider or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(7) of this section.

(j) *Correction of errors.* HCFA may review a past determination of provider-based status if it believes that the determination may be inappropriate, based on the provisions of this section. If HCFA determines that a previous determination was in error, and the entity should not be considered provider-based, HCFA notifies the main provider. Treatment of the facility or organization as provider-based ceases with the first day of the next cost report period following notification of the redetermination.

Subpart F—Specific Categories of Costs

5. In § 413.118, the heading to paragraph (d) is republished, and a new paragraph (d)(5) is added to read as follows:

§ 413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

* * * * *

(d) *Blended payment amount.* * * *

(5) For portions of cost reporting periods beginning on or after October 1, 1997, for purposes of calculating the blended payment amount under paragraph (d)(4) of this section, the ASC payment amount is the sum of the standard overhead amounts reduced by deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

* * * * *

6. In § 413.122, the heading to paragraph (b) is republished, a new

paragraph (b)(5) is added, the heading to paragraph (c) is republished, and a new paragraph (c)(4) is added to read as follows:

413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

* * * * *

(b) *Payment for hospital outpatient radiology services.* * * *

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* * * *

(4) For other diagnostic services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 50 percent of the hospital-specific amount; and

(ii) 50 percent of the fee schedule amount calculated as 42 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

7. In § 413.124, paragraph (a) is revised to read as follows:

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92 of this chapter, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of such services) are reduced by 5.8 percent for services furnished during portions of cost reporting periods occurring on or after October 1, 1990 and before January 1, 2000.

* * * * *

Subpart G—Capital-Related Costs

8. In § 413.130, the heading to paragraph (j) and the introductory text to paragraph (j)(1) are republished, and paragraph (j)(1)(ii) is revised to read as follows:

§ 413.130 Introduction to capital-related costs.

* * * * *

(j) *Reduction to capital-related costs.* (1) Except for sole community hospitals and critical access hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

* * * * *

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991 through December 31, 1999 and before January 1, 2000.

* * * * *

F. A new part 419, consisting of §§ 419.1, 419.2, 419.20, 419.21, 419.22, 419.30, 419.31, 419.32, 419.40, 419.41, 419.42, 419.43, 419.44, 419.50, 419.51, and 419.60, is added to read as follows:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

Sec.
419.1 Scope of part.
419.2 Basis of payment.

Subpart B—Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

419.20 Hospitals subject to the hospital outpatient prospective payment system.
419.21 Hospital outpatient services subject to the outpatient prospective payment system.
419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

419.30 Base expenditure target for calendar year 1999.
419.31 Ambulatory Payment Classification (APC) system and payment weights.
419.32 Calculation of prospective payment rates for hospital outpatient services.

Subpart D—Payments to Hospitals

419.40 Payment concepts.
419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.
419.42 Hospital election to reduce copayment.
419.43 Adjustments to national program payment and beneficiary copayment amounts.
419.44 Payment reductions for surgical procedures.

Subpart E—Updates

419.50 Revisions to groups, weights, and other adjustments.
419.51 Volume control measures for services furnished in CY 2000.

Subpart F—Limitations on Review

419.60 Limitations on administrative and judicial review.

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395(hh)).

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

§ 419.1 Scope of part.

(a) *Purpose.* This part implements section 1833(t) of the Act by establishing a prospective payment system for services furnished by hospital outpatient departments to Medicare beneficiaries who are registered on hospital records as outpatients, effective for services furnished on or after the implementation date.

(b) *Summary of content.* This subpart describes the basis of payment for outpatient hospital services under the prospective payment system. Subpart B sets forth the categories of hospitals and services that are subject to the outpatient hospital prospective payment system and those categories of hospitals and services that are excluded from the outpatient hospital prospective payment system. Subpart C sets forth requirements and the basic methodology by which prospective payment rates for hospital outpatient services are determined. Subpart D describes Medicare payment amounts, beneficiary copayment amounts, and methods of payment to hospitals under the hospital outpatient prospective payment system. Subpart E describes how the hospital outpatient prospective payment system may be revised to take into account changes in medical practice and technology, the addition or deletion of services, new cost data, and other relevant information and factors.

§ 419.2 Basis of payment.

(a) *Unit of payment.* Under the hospital outpatient prospective payment system, hospitals are paid a predetermined amount for designated services, which are identified by codes established under the Health Care Financing Administration Common Procedure Coding System (HCPCS), furnished to Medicare beneficiaries. The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) *Costs included in determination of hospital outpatient department payment rates.* The prospective payment system establishes a national payment rate,

standardized for geographic wage differences, for operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis, including, but not limited to—

(1) Use of an operating suite, procedure room, or treatment room;

(2) Use of recovery room;

(3) Use of an observation bed;

(4) Anesthesia, drugs, biologicals, other pharmaceuticals, and blood; medical and surgical supplies and equipment; surgical dressings; splints, casts, and other devices used for reduction of fractures and dislocations;

(5) Supplies and equipment for administering and monitoring anesthesia or sedation;

(6) Intra-ocular lenses (IOLs);

(7) Incidental services such as venipuncture;

(8) Capital-related costs.

(c) *Costs excluded from determination of hospital outpatient prospective payment rates.* The following costs are excluded from the hospital outpatient prospective payment rates:

(1) Medical education costs for approved nursing and allied health education programs.

(2) Costs for services listed in § 419.22.

Subpart B—Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after the implementation date.

(b) *Hospitals excluded from the outpatient prospective payment system.* (1) Those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the hospital outpatient prospective payment system.

(2) Critical access hospitals (CAHs) are excluded from the hospital outpatient prospective payment system.

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

Beginning on the implementation date, except for services described in § 419.22, payment is made under the hospital outpatient prospective payment system for—

(a) Medicare Part B services furnished to hospital outpatients designated by HCFA under this part that are not otherwise excluded under § 419.22;

(b) Services that are covered under Medicare Part B when furnished to hospital inpatients who are either not entitled to benefits under Part A or who have exhausted their Part A benefits, but are entitled to benefits under Part B of the program;

(c) Partial hospitalization services furnished by community mental health centers (CMHCs);

(d) The following medical and other health services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they fall outside the definition of CORF services at section 1861(cc)(1) of the Act; or by a home health agency (HHA) to patients who are not under an HHA plan or treatment; or, by a hospice program furnishing services to patients outside the hospice benefit:

(1) Antigens.

(2) Splints and casts.

(3) Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine.

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

(a) Physician services.

(b) Nurse practitioner services.

(c) Physician assistant services.

(d) Certified nurse-midwife services.

(e) Services of qualified psychologists.

(f) Services of an anesthetist as defined in § 410.69 of this chapter.

(g) Clinical social worker services as defined in section 1861(hh)(2) of the Act.

(h) Rehabilitation services described in section 1833(a)(8) of the Act.

(i) Ambulance services.

(j) Prosthetics and prosthetic supplies, prosthetic devices, prosthetic implants (except IOLs), and orthotic devices.

(k) Durable medical equipment supplied by the hospital for the patient to take home.

(l) Clinical diagnostic laboratory services.

(m) Dialysis services furnished to ESRD patients.

(n) Services and procedures that are not safely furnished in an outpatient setting or that require inpatient care.

(o) Services specific to other sites such as nursing homes.

(p) Services furnished to persons who are inpatients of a SNF and furnished pursuant to the resident assessment or comprehensive care plan but that are covered under the SNF prospective payment system, furnished ''under arrangement,'' and billable only by the SNF.

(q) Services that are not covered by Medicare by statute.

(r) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§ 419.30 Base expenditure target for calendar year 1999.

(a) HCFA estimates the aggregate amount that would be payable for hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of copayments estimated to be paid by beneficiaries, under the prospective payment system described in this part, to hospitals for covered hospital outpatient services.

(b) The aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

§ 419.31 Ambulatory Payment Classification (APC) system and payment weights.

(a) *APC groups.* (1) HCFA classifies hospital outpatient services and procedures that are comparable clinically and similar in terms of resource use into APC groups.

(2) The payment rate determined for an APC group in accordance with § 419.32 and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part apply to every individual service or procedure within the APC group.

(b) *APC weighting factors.* (1) Using hospital claims data from calendar year 1996 and data from the most recent available hospital cost reports, HCFA determines the median costs for the services and procedures within each APC group.

(2) HCFA assigns to each APC group an appropriate weighting factor to reflect the relative median costs for the services within the APC group compared to the median costs for the services in all APC groups.

(c) *Standardizing amounts.* (1) HCFA determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is known as the ''labor-related portion'' of hospital outpatient costs.

(2) HCFA standardizes the median costs determined in paragraph (b)(1) of

this section by adjusting for variations in hospital labor costs across geographic areas.

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) *Conversion factor for 1999.* HCFA calculates a conversion factor in such a manner as to ensure that payment for hospital outpatient services furnished in 1999 would have equalled the base expenditure target calculated in § 419.30, taking APC group weights and estimated service volume into account.

(b) *Conversion factor for calendar years 2000, 2001, and 2002.* (1) Subject to paragraph (c)(2) of this section, the conversion factor for each of the calendar years 2000, 2001, and 2002 is equal to the conversion factor calculated under paragraph (a) of this section for the previous year adjusted by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act for fiscal years 2000, 2001, and 2002, respectively, reduced by one percentage point.

(2) Beginning in calendar year 2000, HCFA may substitute for the hospital inpatient market basket percentage in paragraph (c)(1) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) *Payment rates.* The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

Subpart D—Payments to Hospitals

§ 419.40 Payment concepts.

In addition to the payment rate described in § 419.32, for each APC group there is a predetermined beneficiary copayment amount as described in § 419.41(a). The Medicare payment for each APC is calculated by applying the program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

Copayment percentage is calculated as the difference between the program payment percentage and 100 percent. The copayment percentage in any year is thus defined for each APC group as the *greater* of the following: the ratio of the APC group unadjusted copayment amount *to* the annual APC group payment rate, or 20 percent.

Program payment percentage is calculated as the *lower* of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, *to* the APC group payment rate, *or* 80 percent.

Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

(a) *Calculation of the national beneficiary copayment amount.* To calculate the unadjusted copayment amount for each APC group, HCFA—

(1) Standardizes 1996 hospital charges for the services within each APC group to offset variations in hospital labor costs across geographic areas;

(2) Identifies the median of the wage-neutralized 1996 charges for each APC group; and,

(3) Determines the value equal to 20 percent of the wage-neutralized 1996 median charge for each APC group and multiplies that value by an actuarial projection of increases in charges for hospital outpatient department services during the period 1996 to 1999. The result is the unadjusted beneficiary copayment amount for the APC group.

(b) *Calculation of the program payment amount for each APC group.* (1) HCFA calculates annually the program payment percentage for every APC group on the basis of each group's unadjusted copayment amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(2) The Medicare program payment amounts are calculated annually by multiplying the updated APC group payment rates by the program payment percentage.

(c) To determine payment amounts due for a service paid for under the hospital outpatient prospective payment system, HCFA makes the following calculations:

(1) Makes the wage index adjustment and any other adjustments that are appropriate in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the program payment amount.

(4) Subtracts the program payment amount from the amount determined in paragraph (c)(2) of this section to determine the copayment amount.

§ 419.42 Hospital election to reduce copayment.

(a) A hospital may elect to reduce copayments for any or all APC groups on a calendar year basis. A hospital may *not* elect to reduce copayment for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce copayments no later than 90 days prior to the start of the calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment level (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced copayment must remain in effect unchanged during the year for which the election was made.

(e) The hospital may advertise and otherwise disseminate information concerning the reduced level(s) of copayment that it has elected.

(f) In electing reduced copayment, a hospital may elect a level that is less than that year's national copayment amount for the group, but not less than 20 percent of the APC payment rate as determined in § 419.32.

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

(a) *General rule.* HCFA determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* HCFA determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the ''labor-related portion'' of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) *Wage index factor.* HCFA uses the hospital inpatient prospective payment system wage index established in accordance with section 1886(d)(3)(E) of the Act and part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) *Other adjustments.* Any other adjustments to payment amounts made by HCFA to ensure equitable payments are made in a budget neutral manner.

§ 419.44 Payment reductions for surgical procedures.

(a) *Multiple surgical procedures.* When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One half of the full program and beneficiary payment amounts for all other covered procedures.

(b) *Terminated procedures.* When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; and

(2) One-half of the full program and beneficiary payment amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed, but before anesthesia is induced.

Subpart E—Updates

§ 419.50 Revisions to groups, weights, and other adjustments.

(a) HCFA periodically reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(1) *Changes in the APC system.* HCFA may make a change in the group composition of the APC system or recalibrate any APC weight, as needed, but not more frequently than once a year. HCFA makes these changes based on evidence that a reassignment would improve the consistency of the group(s) either clinically or with respect to resource consumption.

(2) *New services.* HCFA assigns a new service to the APC group that is most similar clinically and with respect to resource consumption.

(3) *Budget neutrality.* HCFA adjusts the conversion factor so that any adjustments determined under paragraphs (a)(1) through (a)(3) of this section do not increase or decrease the amount of expenditures that would have been made under this section if the adjustments had not been made.

(b) *Annual update to conversion factor.* HCFA updates the conversion factor annually as specified in § 419.32.

§ 419.51 Volume control measures for services furnished in CY 2000.

HCFA uses the target amount specified under section 1833(t)(3)(A) of the Act as an expenditure target for services furnished in CY 1999. HCFA updates the target amount to CY 2000 based on the adjustment to the conversion factor in § 419.32(b), estimated changes in the volume and intensity of hospital outpatient services, and estimated changes in beneficiary enrollment. HCFA compares the CY 2000 target to an estimate of CY 2000 actual payments to hospitals. If unnecessary volume increases cause payments to exceed the target, HCFA determines the percentage by which the target is exceeded, and adjusts the CY 2002 update to the conversion factor by the same percentage.

Subpart F—Limitations on Review

§ 419.60 Limitations on administrative and judicial review.

There can be no administrative or judicial review under sections 1869 and 1878 of the Act, or otherwise of—

(a) The development of the APC system, including—

(1) Establishment of the groups and relative payment weights;

(2) Wage adjustment factors;

(3) Other adjustments; and

(4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act;

(c) Periodic adjustments described in section 1833(t)(6) of the Act; and

(d) The establishment of a separate conversion factor for hospitals described in section 1886(d)(1)(B)(v) of the Act.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

G. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Essentials of Provider Agreements

2. In § 489.20, the introductory text to the section is republished; the introductory text to paragraph (d) is revised; paragraphs (d)(3), (d)(4), and (d)(5) are redesignated as paragraphs (d)(4), (d)(5), and (d)(6), respectively; and a new paragraph (d)(3) is added to read as follows:

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(d) In the case of a hospital or a CAH that furnishes services to Medicare beneficiaries, either to furnish directly or to make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services to inpatients and outpatients of a hospital or a CAH except the following:

* * * * *

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

3. In § 489.24(b), the definition for ''Comes to the emergency department'' is revised to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Comes to the emergency department means, with respect to an individual requesting examination or treatment, that the individual is on the hospital property. For purposes of this section, ''property'' means the entire main hospital campus, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined under § 416.35 of this chapter to be a department of the hospital. Property also includes ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds. An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the hospital's emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In such situations, the hospital may deny access if it is in ''diversionary status,'' that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's instructions and transports the individual on to hospital property, the individual is considered to have come to the emergency department.

* * * * *

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

H. Part 498 is amended as set forth below:

1. The authority citation for part 498 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh).

2. In § 498.2, the introductory text is republished, and the definition of ''Provider'' is revised to read as follows:

§ 498.2 Definitions.

As used in this part —

* * * * *

Provider means a hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that has in effect an agreement to participate in Medicare, that has in effect an agreement to participate in Medicaid, or a clinic, rehabilitation agency, or public health agency that has a similar agreement but only to furnish outpatient physical therapy or outpatient speech pathology services, and *prospective provider* means any of the listed entities that seeks to participate in Medicare as a provider or to have any facility or organization determined to be a department of the provider or provider-based entity under § 412.65 of this chapter.

* * * * *

3. In § 498.3, the introductory text to paragraph (b) is republished; paragraphs (b)(2) through (b)(14) are redesignated as paragraphs (b)(3) through (b)(15), respectively; and a new paragraph (b)(2) is added to read as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) *Initial determinations by HCFA.* HCFA makes initial determinations with respect to the following matters:

* * * * *

(2) Whether a prospective department of a provider or provider-based entity qualifies as a department of a provider or provider-based entity under § 413.65 of this chapter.

* * * * *

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

I. Part 1003 is amended as set forth below:

1. The authority citation for part 1003 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320–7, 1320a-7a, 1320b-10, 1395u(j), 1395u(k), 1395cc(g), 1395dd(d)(1), 1395mm, 1395nn(g), 1395ss(d), 1396b(m), 11131(c) and 11137(b)(2).

2. Section 1003.100 is amended by revising paragraph (a) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1102, 1128(c), 1128A, 1140, 1842(j), 1842(k), 1866(g), 1876(i)(6), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act, and sections 421(c) and 427(b)(2) of Pub. L. 99–660 (42 U.S.C. 1302, 1320a–7, 1320a–7a, 1320b–10, 1395u(j), 1395u(k), 1395cc(g), 1395mm(i)(6), 1395nn(g), 1395ss(d), 1396d(m)(5), 11131(c) and 11137(b)(2)).

* * * * *

3. Section 1003.102 is amended by republishing the introductory text to paragraph (b), by reserving paragraphs (b)(11) through (b)(13), and by adding a new paragraph (b)(14) to read as follows:

§ 1003.102 Basis for civil money penalties and assessments.

* * * * *

(b) The OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

* * * * *

(11) [Reserved]

(12) [Reserved]

(13) [Reserved]

(14) Has knowingly and willfully presented, or caused to be presented, a bill or request for payment for an item or service furnished to a hospital patient for which payment may be made under the Medicare or another Federal health care program, if that bill or request is inconsistent with an arrangement under section 1866(a)(1)(H) of the Act, or violates the requirements for such an arrangement.

* * * * *

4. Section 1003.103 is amended by revising paragraph (a) to read as follows:

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b) through (f) of this section, the OIG may impose a penalty of not more than $10,000 for each item or service that is subject to a determination under § 1003.102.

* * * * *

5. Section 1003.105 is amended by revising paragraph (a)(1)(i) to read as follows:

§ 1003.105 Exclusion from participation in Medicare and State health care programs.

(a)(1) * * *

(i) Any person who is subject to a penalty or assessment under § 1003.102(a), (b)(1) through (b)(4), or (b)(14).

* * * * *

(Catalog of Federal Domestic Assistance 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 29, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: June 29, 1998.

June G. Brown,

Inspector General, Department of Health and Human Services.

Approved: August 15, 1998.

Donna E. Shalala,

Secretary.

Note: The following addenda will not appear in the Code of Federal Regulations.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS

APC [1] [2]	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
020	Partial Hospitalization per diem	S	4.11	$208.01	$46.78	$41.60
031	Dental procedures	S	1.34	$67.90	$13.58	$13.58
061	Level I Chemotherapeutic agents	X	1.04	$52.70	$36.61	$10.54
062	Level II Chemotherapeutic agents	X	1.69	$85.63	$36.61	$17.13

[1] *APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.

[2] +APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC[1 2]	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
063	Level III Chemotherapeutic agents	X	2.89	$146.43	$110.97	$29.29
064	Level IV Chemotherapeutic agents	X	4.17	$211.29	$140.12	$42.26
089	Neuropsychological Testing	X	2.54	$128.70	$37.29	$25.74
090	Monitoring psychiatric drugs	X	0.85	$43.07	$12.43	$8.61
091	Brief Individual Psychotherapy	S	1.09	$55.23	$14.01	$11.05
092	Extended Individual Psychotherapy	S	1.57	$79.55	$21.92	$15.91
093	Family Psychotherapy	S	1.54	$78.03	$20.11	$15.61
094	Group Psychotherapy	S	1.24	$62.83	$20.11	$12.57
121	Level I needle biopsy/aspiration	T	0.67	$33.95	$20.91	$6.79
122	Level II needle biopsy/aspiration	T	4.87	$246.76	$115.03	$49.35
131	Level I incision & drainage	T	1.94	$98.30	$36.61	$19.66
132	Level II incision & drainage	T	6.04	$306.04	$134.13	$61.21
137	Nail procedures	T	0.46	$23.31	$4.66	$4.66
141	Level I Destruction of lesion	T	0.59	$29.90	$9.49	$5.98
142	Level II Destruction of lesion	T	3.77	$191.02	$73.00	$38.20
151	Level I debridement/destruction	T	1.74	$88.16	$35.71	$17.63
152	Level II debridement/destruction	T	10.43	$528.48	$261.71	$105.70
161	Level I excision/biopsy	T	3.50	$177.34	$75.48	$35.47
162	Level II excision/biopsy	T	5.67	$287.30	$125.43	$57.46
163	Level III excision/biopsy	T	10.69	$541.66	$264.65	$108.33
181	Level I skin repair	T	2.19	$110.97	$43.84	$22.19
182	Level II skin repair	T	4.00	$202.68	$84.98	$40.54
183	Level III skin repair	T	11.17	$565.98	$286.46	$113.20
184	Level IV skin repair	T	15.17	$768.66	$396.40	$153.73
197	Incision/excision breast	T	12.13	$614.62	$310.75	$122.92
198	Breast reconstruction/mastectomy	T	19.17	$971.33	$530.20	$194.27
200	Arthrocentesis & Ligament/Tendon Injection	T	1.89	$95.77	$39.10	$19.15
207	Closed treatment fracture finger/toe/trunk	T	1.70	$86.14	$31.64	$17.23
209	Closed treatment fracture/dislocation/except finger/toe/trunk.	T	1.94	$98.30	$37.29	$19.66
210	Bone/joint manipulation under anesthesia	T	10.46	$530.00	$283.40	$106.00
216	Open/percutaneous treatment fracture or dislocation.	T	20.13	$1,019.98	$520.82	$204.00
217	Arthroplasty	T	20.48	$1,037.71	$526.81	$207.54
218	Arthroplasty with prosthesis	T	27.49	$1,392.90	$715.52	$278.58
*226	Maxillofacial prostheses	T	1.59	$80.56	$21.92	$16.11
231	Level I skull and facial bone procedures	T	12.02	$609.05	$299.90	$121.81
232	Level II skull and facial bone procedures	T	23.93	$1,212.52	$639.35	$242.50
251	Level I Musculoskeletal Procedures	T	14.26	$722.55	$366.12	$144.51
252	Level II Musculoskeletal Procedures	T	19.39	$982.48	$509.18	$196.50
253	Level III Musculoskeletal Procedures	T	26.33	$1,334.13	$699.24	$266.83
254	Level IV Musculoskeletal Procedures	T	34.37	$1,741.51	$937.11	$348.30
261	Level I Hand Musculoskeletal Procedures	T	10.54	$534.06	$261.48	$106.81
262	Level II Hand Musculoskeletal Procedures	T	18.35	$929.78	$480.82	$185.96
271	Level I Foot Musculoskeletal Procedures	T	14.41	$730.15	$368.38	$146.03
272	Level II Foot Musculoskeletal Procedures	T	16.56	$839.09	$409.74	$167.82
276	Bunion Procedures	T	19.19	$972.35	$500.14	$194.47
280	Diagnostic Arthroscopy	T	22.20	$1,124.86	$581.72	$224.97
281	Level I Surgical Arthroscopy	T	22.65	$1,147.66	$590.20	$229.53
282	Level II Surgical Arthroscopy	T	23.94	$1,213.03	$614.04	$242.61
286	Arthroscopically-Aided Procedures	T	26.76	$1,355.91	$802.41	$271.18
311	Level I ENT Procedures	T	1.43	$72.46	$20.57	$14.49
312	Level II ENT Procedures	T	7.26	$367.86	$178.31	$73.57
313	Level III ENT Procedures	T	15.81	$801.08	$411.09	$160.22
314	Level IV ENT Procedures	T	25.65	$1,299.67	$693.37	$259.93
*317	Implantation of Cochlear Device	T				
318	Nasal Cauterization/Packing	T	2.07	$104.89	$38.65	$20.98
319	Tonsil/Adenoid Procedures	T	17.30	$876.58	$480.02	$175.32
320	Thoracentesis/Lavage Procedures	T	3.17	$160.62	$79.33	$32.12
331	Level I Endoscopy Upper Airway	T	0.69	$34.96	$14.01	$6.99
332	Level II Endoscopy Upper Airway	T	9.74	$493.52	$244.98	$98.70
333	Level III Endoscopy Upper Airway	T	17.24	$873.54	$464.20	$174.71
336	Endoscopy Lower Airway	T	7.44	$376.98	$197.98	$75.40
339	Injection of Sclerosing Solution	T	1.02	$51.68	$19.66	$10.34
341	Level I Needle and Catheter Placement	T	0.13	$6.59	$2.94	$1.32
342	Level II Needle and Catheter Placement	T	3.20	$162.14	$80.23	$32.43
343	Level III Needle and Catheter Placement	T	9.52	$482.37	$224.87	$96.47
346	Placement Transvenous Caths/Cutdown	T	4.83	$244.73	$120.23	$48.95
347	Injection Procedures for Interventional Radiology.	T	2.93	$148.46	$62.15	$29.69
360	Removal/Revision, Pacemaker/Vascular Device.	T	6.09	$308.58	$140.12	$61.72
367	Vascular Ligation	T	17.59	$891.28	$449.06	$178.26
368	Vascular Repair/Fistula Construction	T	22.83	$1,156.78	$648.85	$231.36
369	Blood and Blood Product Exchange	T	4.33	$219.40	$97.18	$43.88

[1] *APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.

[2] +APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC [1] [2]	Group title	Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
396	Lymph Node Excisions	T	13.28	$672.89	$338.77	$134.58
397	Thyroid/Lymphadenectomy Procedures	T	18.36	$930.29	$496.86	$186.06
406	Esophageal Dilation without Endoscopy	T	4.31	$218.39	$108.48	$43.68
407	Esophagoscopy	T	7.06	$357.73	$189.84	$71.55
417	Diagnostic Upper GI Endoscopy	T	6.44	$326.31	$181.70	$65.26
418	Therapeutic Upper GI Endoscopy	T	7.59	$384.58	$214.25	$76.92
419	Small Intestine Endoscopy	T	7.13	$361.27	$164.08	$72.25
426	Diagnostic Lower GI Endoscopy	T	6.85	$347.09	$187.81	$69.42
427	Therapeutic Lower GI Endoscopy	T	8.22	$416.50	$224.19	$83.30
437	Therapeutic Anoscopy	T	2.91	$147.45	$76.61	$29.49
446	Diagnostic Sigmoidoscopy	T	2.59	$131.23	$65.09	$26.25
447	Therapeutic Proctosigmoidoscopy	T	6.87	$348.10	$184.76	$69.62
448	Therapeutic Flexible Sigmoidoscopy	T	5.37	$272.09	$141.25	$54.42
449	Complex GI Endoscopy	T	7.80	$395.22	$215.38	$79.04
451	Level I Anal/Rectal Procedures	T	2.56	$129.71	$54.24	$25.94
452	Level II Anal/Rectal Procedures	T	4.82	$244.23	$109.61	$48.85
453	Level III Anal/Rectal Procedures	T	16.87	$854.79	$445.22	$170.96
456	Endoscopic Retrograde Cholangio-Pancreatography (ERCP).	T	9.78	$495.55	$257.19	$99.11
458	Percutaneous Biliary Endoscopic Procedures.	T	7.23	$366.34	$181.59	$73.27
459	Peritoneal and Abdominal Procedures	T	18.06	$915.09	$496.52	$183.02
466	Hernia/Hydrocele Procedures	T	21.43	$1,085.85	$562.97	$217.17
470	Tube Procedures	T	2.22	$112.49	$54.92	$22.50
521	Level I Cystourethroscopy and other Genitourinary Procedures.	T	5.06	$256.39	$112.10	$51.28
522	Level II Cystourethroscopy and other Genitourinary Procedures.	T	10.46	$530.00	$262.39	$106.00
523	Level III Cystourethroscopy and other Genitourinary Procedures.	T	16.87	$854.79	$447.03	$170.96
524	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	28.89	$1,463.84	$833.38	$292.77
527	Lithotripsy	T	51.56	$2,612.52	$1,372.95	$522.50
529	Simple Urinary Studies and Procedures	T	2.50	$126.67	$63.05	$25.33
530	Genitourinary Procedures	T	2.52	$127.69	$54.69	$25.54
531	Level I Urethral Procedures	T	18.94	$959.68	$527.26	$191.94
532	Level II Urethral Procedures	T	25.50	$1,292.07	$602.18	$258.41
536	Circumcision	T	13.17	$667.32	$326.57	$133.46
537	Penile Procedures	T	28.72	$1,455.23	$864.34	$291.05
538	Insertion of Penile Prosthesis	T	45.59	$2,310.02	$1,540.64	$462.00
546	Testes/Epididymis Procedures	T	17.14	$868.47	$453.81	$173.69
547	Prostate Biopsy	T	4.39	$222.44	$125.20	$44.49
550	Surgical Hysteroscopy	T	16.89	$855.81	$447.93	$171.16
551	Level I Laparoscopy	T	24.78	$1,255.59	$711.67	$251.12
552	Level II Laparoscopy	T	37.71	$1,910.75	$1,053.16	$382.15
561	Level I Female Reproductive Procedures	T	1.52	$77.02	$24.63	$15.40
562	Level II Female Reproductive Procedures	T	12.76	$646.54	$330.75	$129.31
563	Level III Female Reproductive Procedures	T	16.90	$856.31	$464.88	$171.26
567	D & C	T	13.61	$689.61	$364.09	$137.92
568	Infertility Procedures	T	2.49	$126.17	$49.49	$25.23
578	Pregnancy and Neonatal Care Procedures	T	1.26	$63.84	$33.90	$12.77
580	Vaginal Delivery	T	4.59	$232.57	$146.34	$46.51
586	Therapeutic Abortion	T	12.50	$633.37	$431.89	$126.67
587	Spontaneous Abortion	T	13.25	$671.37	$347.02	$134.27
600	Spinal Tap	T	2.63	$133.26	$61.47	$26.65
601	Level I Nervous System Injections	T	3.11	$157.58	$74.13	$31.52
602	Level II Nervous System Injections	T	3.33	$168.73	$87.69	$33.75
616	Implantation of Neurostimulator Electrodes	T	14.43	$731.16	$366.57	$146.23
617	Revision/Removal Neurological Device	T	11.56	$585.74	$287.59	$117.15
618	Implantation of Neurological Device	T	25.56	$1,295.11	$780.49	$259.02
631	Level I Nerve Procedures	T	12.98	$657.69	$333.80	$131.54
632	Level II Nerve Procedures	T	18.13	$918.64	$461.04	$183.73
648	Laser Retinal Procedures	T	3.94	$199.64	$95.15	$39.93
649	Laser Eye Procedures except Retinal	T	4.44	$224.97	$111.64	$44.99
651	Level I Anterior Segment Eye Procedures	T	7.24	$366.85	$174.70	$73.37
652	Level II Anterior Segment Eye Procedures	T	16.48	$835.03	$433.69	$167.01
667	Cataract Procedures	T	15.33	$776.40	$521.72	$155.28
668	Cataract Procedures with IOL Insert	T	19.28	$976.91	$530.87	$195.38
670	Corneal Transplant	T	29.23	$1,481.07	$847.50	$296.21
676	Posterior Segment Eye Procedures	T	6.30	$319.22	$140.35	$63.84
677	Strabismus/Muscle Procedures	T	16.26	$823.89	$436.63	$164.78
681	Level I Eye Procedures	T	1.67	$84.62	$30.51	$16.92
682	Level II Eye Procedures	T	3.54	$179.37	$81.36	$35.87
683	Level III Eye Procedures	T	10.19	$516.32	$257.87	$103.26
684	Level IV Eye Procedures	T	13.48	$683.02	$348.94	$136.60

[1] *APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.

[2] +APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC[1][2]	Group title		Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
690	Vitrectomy		T	30.54	$1,547.45	$852.02	$309.49
700	Plain Film		X	0.78	$39.52	$22.37	$7.90
706	Miscellaneous Radiological Procedures		X	1.96	$99.31	$57.63	$19.86
710	Computerized Axial Tomography		S	5.06	$256.39	$176.28	$51.28
716	Fluoroscopy		X	1.59	$80.56	$47.91	$16.11
720	Magnetic Resonance Angiography		S	6.34	$321.24	$206.11	$64.25
726	Magnetic Resonance Imaging		S	7.96	$403.33	$258.09	$80.67
728	Myelography		S	4.07	$206.22	$113.23	$41.24
730	Arthography		S	2.48	$125.66	$72.09	$25.13
736	Digestive Radiology		S	1.85	$93.74	$54.24	$18.75
737	Diagnostic Urography		S	2.81	$142.38	$86.56	$28.48
738	Therapeutic Radiologic Procedures		S	4.48	$227.00	$133.23	$45.40
739	Diagnostic Angiography and Venography		S	5.83	$295.40	$168.71	$59.08
746	Mammography		S	0.69	$34.96	$19.44	$6.99
747	Diagnostic Ultrasound Except Vascular		S	1.65	$83.60	$54.69	$16.72
749	Guidance under Ultrasound		X	2.44	$123.63	$76.16	$24.73
750	Therapeutic Radiation Treatment Planning		X	0.91	$46.11	$25.54	$9.22
751	Level I Therapeutic Radiation Treatment Preparation.		X	1.15	$58.27	$33.22	$11.65
752	Level II Therapeutic Radiation Treatment Preparation.		X	3.54	$179.37	$88.82	$35.87
757	Radiation Therapy		S	2.30	$116.54	$52.43	$23.31
758	Hyperthermic Therapies		S	3.41	$172.78	$76.84	$34.56
759	Brachytherapy and Complex Radioelement Applications.		S	7.98	$404.34	$160.01	$80.87
760	PET Scans		S	17.26	$874.55	$419.46	$174.91
*761	Standard Non-Imaging Nuclear Medicine		S	2.04	$103.37	$61.47	$20.67
*762	Complex Non-Imaging Nuclear Medicine		S	1.78	$90.19	$51.53	$18.04
771	Standard Planar Nuclear Medicine		S	3.78	$191.53	$116.84	$38.31
772	Complex Planar Nuclear Medicine		S	4.22	$213.83	$127.92	$42.77
781	Standard SPECT Nuclear Medicine		S	5.26	$266.52	$145.77	$53.30
782	Complex SPECT Nuclear Medicine		S	9.28	$470.21	$275.04	$94.04
*791	Standard Therapeutic Nuclear Medicine		S	15.83	$802.10	$562.06	$160.42
*792	Complex Therapeutic Nuclear Medicine		S	4.80	$243.21	$144.19	$48.64
861	Immunology Tests		X	0.13	$6.59	$3.62	$1.32
881	Level I Pathology		X	0.20	$10.13	$6.78	$2.03
882	Level II Pathology		X	0.39	$19.76	$11.75	$3.95
883	Level III Pathology		X	0.65	$32.94	$20.34	$6.59
900	Critical Care		V	7.44	$376.98	$144.87	$75.40
901	Level I Immunization		X	0.07	$3.55	$2.49	$0.71
*902	Level II Immunization		X	1.78	$90.19	$41.47	$18.04
*903	Level III Immunization		X	1.16	$58.78	$25.65	$11.76
906	Infusion Therapy except Chemotherapy		X	1.46	$73.98	$42.49	$14.80
907	Intramuscular Injections		X	0.85	$43.07	$11.98	$8.61
+91111	Low Level Clinic Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
91118	Low Level Clinic Visits	Skin and breast diseases	V	0.83	$42.06	$9.27	$8.41
91124	Low Level Clinic Visits	Musculoskeletal diseases	V	0.87	$44.08	$9.49	$8.82
91131	Low Level Clinic Visits	Ear, nose, mouth and throat diseases	V	0.81	$41.04	$9.04	$8.21
91133	Low Level Clinic Visits	Respiratory system diseases	V	0.80	$40.54	$8.59	$8.11
91136	Low Level Clinic Visits	Cardiovascular system diseases	V	0.85	$43.07	$8.61	$8.61
91141	Low Level Clinic Visits	Digestive system diseases	V	0.98	$49.66	$10.40	$9.93
91153	Low Level Clinic Visits	Kidney, urinary tract and male genital diseases.	V	0.91	$46.11	$9.27	$9.22
91156	Low Level Clinic Visits	Female genital system diseases	V	0.93	$47.12	$9.42	$9.42
*91157	Low Level Clinic Visits	Pregnancy and neonatal care	V	1.33	$67.39	$14.46	$13.48
91163	Low Level Clinic Visits	Nervous system diseases	V	0.98	$49.66	$10.17	$9.93
*91168	Low Level Clinic Visits	Eye diseases	V	0.98	$49.66	$10.62	$9.93
*91172	Low Level Clinic Visits	Trauma and poisoning	V	1.06	$53.71	$14.24	$10.74
*91178	Low Level Clinic Visits	Major signs, symptoms and findings	V	1.52	$77.02	$21.58	$15.40
91182	Low Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	0.87	$44.08	$9.04	$8.82
*91186	Low Level Clinic Visits	Immunologic and hematologic diseases	V	1.09	$55.23	$11.30	$11.05
91188	Low Level Clinic Visits	Malignancy	V	0.72	$36.48	$8.14	$7.30
+91191	Low Level Clinic Visits	Psychiatric disorders	V	1.09	$55.23	$14.01	$11.05
91197	Low Level Clinic Visits	Infectious disease	V	1.02	$51.68	$11.53	$10.34
+91199	Low Level Clinic Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+91311	Mid Level Clinic Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
91318	Mid Level Clinic Visits	Skin and breast diseases	V	0.98	$49.66	$9.93	$9.93
91324	Mid Level Clinic Visits	Musculoskeletal diseases	V	0.98	$49.66	$9.93	$9.93
91331	Mid Level Clinic Visits	Ear, nose, mouth and throat diseases	V	0.94	$47.63	$9.53	$9.53
91333	Mid Level Clinic Visits	Respiratory system diseases	V	0.93	$47.12	$9.42	$9.42
91336	Mid Level Clinic Visits	Cardiovascular system diseases	V	1.00	$50.67	$10.13	$10.13
91341	Mid Level Clinic Visits	Digestive system diseases	V	1.00	$50.67	$10.13	$10.13
91353	Mid Level Clinic Visits	Kidney, urinary tract and male genital diseases.	V	1.04	$52.70	$10.54	$10.54

[1] *APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.

[2] +APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC [1] [2]	Group title		Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
91356	Mid Level Clinic Visits	Female genital system diseases	V	1.06	$53.71	$10.74	$10.74
*91357	Mid Level Clinic Visits	Pregnancy and neonatal care	V	1.22	$61.82	$12.66	$12.36
91363	Mid Level Clinic Visits	Nervous system diseases	V	1.04	$52.70	$10.54	$10.54
*91368	Mid Level Clinic Visits	Eye diseases	V	0.87	$44.08	$8.82	$8.82
*91372	Mid Level Clinic Visits	Trauma and poisoning	V	1.06	$53.71	$10.85	$10.74
*91378	Mid Level Clinic Visits	Major signs, symptoms and findings	V	1.13	$57.26	$11.45	$11.45
91382	Mid Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	1.00	$50.67	$10.13	$10.13
*91386	Mid Level Clinic Visits	Immunologic and hematologic diseases	V	1.04	$52.70	$10.54	$10.54
91388	Mid Level Clinic Visits	Malignancy	V	0.83	$42.06	$8.41	$8.41
+91391	Mid Level Clinic Visits	Psychiatric disorders	V	1.09	$55.23	$14.01	$11.05
91397	Mid Level Clinic Visits	Infectious disease	V	1.06	$53.71	$10.74	$10.74
+91399	Mid Level Clinic Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+91511	High Level Clinic Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
91518	High Level Clinic Visits	Skin and breast diseases	V	1.69	$85.63	$19.21	$17.13
91524	High Level Clinic Visits	Musculoskeletal diseases	V	1.37	$69.42	$15.37	$13.88
91531	High Level Clinic Visits	Ear, nose, mouth and throat diseases	V	1.31	$66.38	$14.92	$13.28
91533	High Level Clinic Visits	Respiratory system diseases	V	1.33	$67.39	$13.79	$13.48
91536	High Level Clinic Visits	Cardiovascular system diseases	V	1.43	$72.46	$15.37	$14.49
91541	High Level Clinic Visits	Digestive system diseases	V	1.50	$76.00	$16.05	$15.20
91553	High Level Clinic Visits	Kidney, urinary tract and male genital diseases.	V	1.30	$65.87	$14.01	$13.17
91556	High Level Clinic Visits	Female genital system diseases	V	1.43	$72.46	$14.49	$14.49
91557	High Level Clinic Visits	Pregnancy and neonatal care	V	1.81	$91.71	$22.15	$18.34
91563	High Level Clinic Visits	Nervous system diseases	V	1.50	$76.00	$16.72	$15.20
91568	High Level Clinic Visits	Eye diseases	V	1.31	$66.38	$13.79	$13.28
91572	High Level Clinic Visits	Trauma and poisoning	V	1.69	$85.63	$22.15	$17.13
91578	High Level Clinic Visits	Major signs, symptoms and findings	V	1.89	$95.77	$29.15	$19.15
91582	High Level Clinic Visits	Endocrine, nutritional and metabolic diseases.	V	1.41	$71.44	$15.14	$14.29
91586	High Level Clinic Visits	Immunologic and hematologic diseases	V	1.65	$83.60	$18.98	$16.72
91588	High Level Clinic Visits	Malignancy	V	1.09	$55.23	$12.43	$11.05
91591	High Level Clinic Visits	Psychiatric disorders	V	1.57	$79.55	$21.92	$15.91
91597	High Level Clinic Visits	Infectious disease	V	1.76	$89.18	$19.66	$17.84
+91599	High Level Clinic Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
919	Electroconvulsive Therapy		S	3.17	$160.62	$80.00	$32.12
920	Biofeedback and other Training		S	1.17	$59.28	$29.61	$11.86
*921	Diabetes Education		S				
926	Dialysis for other than ESRD patients		S	4.28	$216.87	$69.83	$43.37
928	Alimentary Tests		X	3.11	$157.58	$83.85	$31.52
930	Minor Eye Examinations		X	1.02	$51.68	$22.83	$10.34
931	Level I Eye Tests		X	0.74	$37.50	$21.47	$7.50
932	Level II Eye Tests		X	2.52	$127.69	$65.09	$25.54
936	Fitting of Vision Aids		X	0.52	$26.35	$9.49	$5.27
940	Otorhinolaryngologic Function Tests		X	3.04	$154.04	$51.98	$30.81
941	Level I Audiometry		X	0.74	$37.50	$13.56	$7.50
942	Level II Audiometry		X	1.48	$74.99	$22.15	$15.00
947	Resuscitation and Cardioversion		S	4.07	$206.22	$109.61	$41.24
948	Cardiac Rehabilitation		X	0.81	$41.04	$16.95	$8.21
949	Cardiovascular Stress Test		X	1.46	$73.98	$62.83	$14.80
950	Electrocardiogram (ECG)		X	0.35	$17.73	$15.82	$3.55
+95111	Low Level ER Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
95118	Low Level ER Visits	Skin and breast diseases	V	1.17	$59.28	$19.21	$11.86
95124	Low Level ER Visits	Musculoskeletal diseases	V	1.17	$59.28	$19.89	$11.86
95131	Low Level ER Visits	Ear, nose, mouth and throat diseases	V	1.11	$56.24	$17.63	$11.25
95133	Low Level ER Visits	Respiratory system diseases	V	1.15	$58.27	$18.31	$11.65
95136	Low Level ER Visits	Cardiovascular system diseases	V	1.24	$62.83	$19.89	$12.57
95141	Low Level ER Visits	Digestive system diseases	V	1.30	$65.87	$21.02	$13.17
95153	Low Level ER Visits	Kidney, urinary tract and male genital diseases.	V	1.43	$72.46	$24.41	$14.49
95156	Low Level ER Visits	Female genital system diseases	V	1.41	$71.44	$23.73	$14.29
95157	Low Level ER Visits	Pregnancy and neonatal care	V	1.44	$72.96	$24.18	$14.59
95163	Low Level ER Visits	Nervous system diseases	V	1.31	$66.38	$22.83	$13.28
95168	Low Level ER Visits	Eye diseases	V	1.20	$60.80	$20.79	$12.16
95172	Low Level ER Visits	Trauma and poisoning	V	1.28	$64.86	$22.15	$12.97
95178	Low Level ER Visits	Major signs, symptoms and findings	V	2.02	$102.35	$37.97	$20.47
95182	Low Level ER Visits	Endocrine, nutritional and metabolic diseases.	V	1.50	$76.00	$24.63	$15.20
95186	Low Level ER Visits	Immunologic and hematologic diseases	V	1.43	$72.46	$25.76	$14.49
95188	Low Level ER Visits	Malignancy	V	1.52	$77.02	$26.44	$15.40
95191	Low Level ER Visits	Psychiatric Disorders	V	1.09	$55.23	$14.01	$11.05
95197	Low Level ER Visits	Infectious disease	V	1.24	$62.83	$20.57	$12.57
+95199	Low Level ER Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+95311	Mid Level ER Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
95318	Mid Level ER Visits	Skin and breast diseases	V	1.89	$95.77	$34.80	$19.15

[1] *APCs preceded by an asterisk have anomalous weights. Refer to the Preamble for discussion.

[2] +APCs preceded by a plus sign (+) indicate the median cost of all claims in combined levels of the MDC was calculated; one rate is paid for multiple levels.

ADDENDUM A.—LIST OF PROPOSED HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC [1] [2]	Group title		Status indicator	Relative weight	Payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
95324	Mid Level ER Visits	Musculoskeletal diseases	V	1.78	$90.19	$32.32	$18.04
95331	Mid Level ER Visits	Ear, nose, mouth and throat diseases	V	1.81	$91.71	$31.64	$18.34
95333	Mid Level ER Visits	Respiratory system diseases	V	1.91	$96.78	$33.67	$19.36
95336	Mid Level ER Visits	Cardiovascular system diseases	V	2.02	$102.35	$36.16	$20.47
95341	Mid Level ER Visits	Digestive system diseases	V	2.02	$102.35	$36.61	$20.47
95353	Mid Level ER Visits	Kidney, urinary tract and male genital diseases.	V	2.06	$104.38	$38.19	$20.88
95356	Mid Level ER Visits	Female genital system diseases	V	2.04	$103.37	$36.61	$20.67
95357	Mid Level ER Visits	Pregnancy and neonatal care	V	2.06	$104.38	$39.78	$20.88
95363	Mid Level ER Visits	Nervous system diseases	V	2.00	$101.34	$37.29	$20.27
95368	Mid Level ER Visits	Eye diseases	V	1.69	$85.63	$33.00	$17.13
95372	Mid Level ER Visits	Trauma and poisoning	V	2.02	$102.35	$38.87	$20.47
95378	Mid Level ER Visits	Major signs, symptoms and findings	V	3.07	$155.56	$58.76	$31.11
95382	Mid Level ER Visits	Endocrine, nutritional and metabolic diseases.	V	2.30	$116.54	$43.62	$23.31
95386	Mid Level ER Visits	Immunologic and hematologic diseases	V	2.39	$121.10	$47.01	$24.22
95388	Mid Level ER Visits	Malignancy	V	2.15	$108.94	$41.13	$21.79
95391	Mid Level ER Visits	Psychiatric Disorders	V	2.00	$101.34	$35.93	$20.27
95397	Mid Level ER Visits	Infectious disease	V	1.98	$100.33	$36.61	$20.07
+95399	Mid Level ER Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
+95511	High Level ER Visits	Well care and administrative	V	1.06	$53.71	$12.66	$10.74
95518	High Level ER Visits	Skin and breast diseases	V	2.61	$132.25	$46.56	$26.45
95524	High Level ER Visits	Musculoskeletal diseases	V	2.44	$123.63	$41.36	$24.73
95531	High Level ER Visits	Ear, nose, mouth and throat diseases	V	2.56	$129.71	$44.07	$25.94
95533	High Level ER Visits	Respiratory system diseases	V	3.19	$161.64	$54.69	$32.33
95536	High Level ER Visits	Cardiovascular system diseases	V	3.17	$160.62	$54.69	$32.12
95541	High Level ER Visits	Digestive system diseases	V	2.89	$146.43	$54.69	$29.29
95553	High Level ER Visits	Kidney, urinary tract and male genital diseases.	V	2.89	$146.43	$54.69	$29.29
95556	High Level ER Visits	Female genital system diseases	V	2.73	$138.33	$50.85	$27.67
95557	High Level ER Visits	Pregnancy and neonatal care	V	2.93	$148.46	$54.92	$29.69
95563	High Level ER Visits	Nervous system diseases	V	3.04	$154.04	$58.08	$30.81
95568	High Level ER Visits	Eye diseases	V	2.31	$117.05	$40.00	$23.41
95572	High Level ER Visits	Trauma and poisoning	V	2.74	$138.83	$50.17	$27.77
95578	High Level ER Visits	Major signs, symptoms and findings	V	6.85	$347.09	$148.48	$69.42
95582	High Level ER Visits	Endocrine, nutritional and metabolic diseases.	V	3.28	$166.20	$64.64	$33.24
95586	High Level ER Visits	Immunologic and hematologic diseases	V	3.70	$187.48	$74.35	$37.50
95588	High Level ER Visits	Malignancy	V	3.67	$185.96	$61.70	$37.19
95591	High Level ER Visits	Psychiatric Disorders	V	3.48	$176.33	$62.38	$35.27
95597	High Level ER Visits	Infectious disease	V	2.81	$142.38	$53.34	$28.48
+95599	High Level ER Visits	Unknown cause of mortality	V	1.31	$66.38	$20.79	$13.28
956	Continuous ECG and Blood Pressure Monitoring.		X	1.11	$56.24	$55.82	$11.25
957	Echocardiography		S	2.83	$143.39	$117.07	$28.68
958	Diagnostic Cardiac Catheterization		T	26.11	$1,322.98	$659.47	$264.60
960	Cardiac Electrophysiologic Tests/Procedures.		S	4.24	$214.84	$144.41	$42.97
966	Electronic Analysis of Pacemakers/other Devices.		X	0.39	$19.76	$12.43	$3.95
967	Non-Invasive Vascular Studies		X	1.70	$86.14	$57.40	$17.23
968	Vascular Ultrasound		X	2.37	$120.09	$79.55	$24.02
969	Hyperbaric Oxygen		S	2.65	$134.27	$141.70	$26.85
971	Level I Pulmonary Tests		X	0.78	$39.52	$21.47	$7.90
972	Level II Pulmonary Tests		X	1.02	$51.68	$29.38	$10.34
973	Level III Pulmonary Tests		S	1.89	$95.77	$55.82	$19.15
976	Pulmonary Therapy		S	0.44	$22.29	$14.92	$4.46
977	Allergy Tests		X	0.63	$31.92	$12.66	$6.38
978	Allergy Injections		X	0.31	$15.71	$3.39	$3.14
979	Extended EEG Studies and Sleep Studies		S	10.17	$515.31	$288.83	$103.06
980	Electroencephalogram		S	2.15	$108.94	$57.86	$21.79
*981	Level I Nerve and Muscle Tests		X	1.46	$73.98	$41.81	$14.80
*982	Level II Nerve and Muscle Tests		X	1.39	$70.43	$38.87	$14.09
987	Subcutaneous or Intramuscular Chemotherapy.		S	0.65	$32.94	$13.33	$6.59
988	Chemotherapy except by Extended Infusion.		S	4.15	$210.28	$97.52	$42.06
989	Chemotherapy by Extended Infusion		S	1.72	$87.15	$40.68	$17.43
990	Photochemotherapy		S	0.43	$21.79	$8.14	$4.36
997	Manipulation Therapy		S	0.69	$34.96	$7.23	$6.99
999	Therapeutic Phlebotomy		X	0.43	$21.79	$10.85	$4.36

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
00100	N	Anesth, skin surgery					
00102	N	Anesth, repair of cleft lip					
00103	N	Anesth, blepharoplasty					
00104	N	Anesth for electroshock					
00120	N	Anesthesia for ear surgery					
00124	N	Anesthesia for ear exam					
00126	N	Anesth, tympanotomy					
00140	N	Anesth, procedures on eye					
00142	N	Anesthesia for lens surgery					
00144	N	Anesth, corneal transplant					
00145	N	Anesth, vitrectomy					
00147	N	Anesth, iridectomy					
00148	N	Anesthesia for eye exam					
00160	N	Anesth, nose, sinus surgery					
00162	N	Anesth, nose, sinus surgery					
00164	N	Anesth, biopsy of nose					
00170	N	Anesth, procedure on mouth					
00172	N	Anesth, cleft palate repair					
00174	C	Anesth, pharyngeal surgery					
00176	C	Anesth, pharyngeal surgery					
00190	N	Anesth, facial bone surgery					
00192	C	Anesth, facial bone surgery					
00210	N	Anesth, open head surgery					
00212	N	Anesth, skull drainage					
00214	C	Anesth, skull drainage					
00215	C	Anesth, skull fracture					
00216	N	Anesth, head vessel surgery					
00218	N	Anesth, special head surgery					
00220	N	Anesth, spinal fluid shunt					
00222	N	Anesth, head nerve surgery					
00300	N	Anesth, skin surgery, neck					
00320	N	Anesth, neck organ surgery					
00322	N	Anesth, biopsy of thyroid					
00350	N	Anesth, neck vessel surgery					
00352	N	Anesth, neck vessel surgery					
00400	N	Anesth, chest skin surgery					
00402	N	Anesth, surgery of breast					
00404	C	Anesth, surgery of breast					
00406	C	Anesth, surgery of breast					
00410	N	Anesth, correct heart rhythm					
00420	N	Anesth, skin surgery, back					
00450	N	Anesth, surgery of shoulder					
00452	C	Anesth, surgery of shoulder					
00454	N	Anesth, collarbone biopsy					
00470	N	Anesth, removal of rib					
00472	N	Anesth, chest wall repair					
00474	C	Anesth, surgery of rib(s)					
00500	N	Anesth, esophageal surgery					
00520	N	Anesth, chest procedure					
00522	N	Anesth, chest lining biopsy					
00524	C	Anesth, chest drainage					
00528	N	Anesth, chest partition view					
00530	C	Anesth, pacemaker insertion					
00532	N	Anesth, vascular access					
00534	N	Anesth, cardioverter/defib					
00540	C	Anesth, chest surgery					
00542	C	Anesth, release of lung					
00544	C	Anesth, chest lining removal					
00546	C	Anesth, lung,chest wall surg					
00548	N	Anesth, trachea,bronchi surg					
00560	C	Anesth, open heart surgery					
00562	C	Anesth, open heart surgery					
00580	C	Anesth,heart/lung transplant					
00600	N	Anesth, spine, cord surgery					
00604	C	Anesth, surgery of vertebra					
00620	N	Anesth, spine, cord surgery					
00622	C	Anesth, removal of nerves					
00630	N	Anesth, spine, cord surgery					
00632	C	Anesth, removal of nerves					
00634	C	Anesth for chemonucleolysis					
00670	C	Anesth, spine, cord surgery					
00700	N	Anesth, abdominal wall surg					
00702	N	Anesth, for liver biopsy					
00730	N	Anesth, abdominal wall surg					
00740	N	Anesth, gi visualization					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
00750	N	Anesth, repair of hernia					
00752	N	Anesth, repair of hernia					
00754	N	Anesth, repair of hernia					
00756	N	Anesth, repair of hernia					
00770	N	Anesth, blood vessel repair					
00790	N	Anesth, surg upper abdomen					
00792	C	Anesth, part liver removal					
00794	C	Anesth, pancreas removal					
00796	C	Anesth, for liver transplant					
00800	N	Anesth, abdominal wall surg					
00802	C	Anesth, fat layer removal					
00810	N	Anesth, intestine endoscopy					
00820	N	Anesth, abdominal wall surg					
00830	N	Anesth, repair of hernia					
00832	N	Anesth, repair of hernia					
00840	N	Anesth, surg lower abdomen					
00842	N	Anesth, amniocentesis					
00844	C	Anesth, pelvis surgery					
00846	C	Anesth, hysterectomy					
00848	C	Anesth, pelvic organ surg					
00850	C	Anesth, cesarean section					
00855	C	Anesth, hysterectomy					
00857	C	Analgesia, labor & c-section					
00860	N	Anesth, surgery of abdomen					
00862	N	Anesth, kidney, ureter surg					
00864	C	Anesth, removal of bladder					
00865	C	Anesth, removal of prostate					
00866	C	Anesth, removal of adrenal					
00868	C	Anesth, kidney transplant					
00870	N	Anesth, bladder stone surg					
00872	N	Anesth,kidney stone destruct					
00873	N	Anesth,kidney stone destruct					
00880	N	Anesth, abdomen vessel surg					
00882	C	Anesth, major vein ligation					
00884	C	Anesth, major vein revision					
00900	N	Anesth, perineal procedure					
00902	N	Anesth, anorectal surgery					
00904	C	Anesth, perineal surgery					
00906	N	Anesth, removal of vulva					
00908	C	Anesth, removal of prostate					
00910	N	Anesth, bladder surgery					
00912	N	Anesth, bladder tumor surg					
00914	N	Anesth, removal of prostate					
00916	N	Anesth, bleeding control					
00918	N	Anesth, stone removal					
00920	N	Anesth, genitalia surgery					
00922	N	Anesth, sperm duct surgery					
00924	N	Anesth, testis exploration					
00926	N	Anesth, removal of testis					
00928	C	Anesth, removal of testis					
00930	N	Anesth, testis suspension					
00932	C	Anesth, amputation of penis					
00934	C	Anesth, penis, nodes removal					
00936	C	Anesth, penis, nodes removal					
00938	N	Anesth, insert penis device					
00940	N	Anesth, vaginal procedures					
00942	N	Anesth, surgery on vagina					
00944	C	Anesth, vaginal hysterectomy					
00946	N	Anesth, vaginal delivery					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, uterine endoscopy					
00955	C	Analgesia, vaginal delivery					
01000	N	Anesth, skin surgery, pelvis					
01110	N	Anesth, skin surgery, pelvis					
01120	N	Anesth, pelvis surgery					
01130	N	Anesth, body cast procedure					
01140	C	Anesth, amputation at pelvis					
01150	C	Anesth, pelvic tumor surgery					
01160	N	Anesth, pelvis procedure					
01170	N	Anesth, pelvis surgery					
01180	N	Anesth, pelvis nerve removal					
01190	C	Anesth, pelvis nerve removal					
01200	N	Anesth, hip joint procedure					
01202	N	Anesth, arthroscopy of hip					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
01210	N	Anesth, hip joint surgery					
01212	C	Anesth, hip disarticulation					
01214	C	Anesth, replacement of hip					
01220	N	Anesth, procedure on femur					
01230	N	Anesth, surgery of femur					
01232	C	Anesth, amputation of femur					
01234	C	Anesth, radical femur surg					
01240	N	Anesth, upper leg skin surg					
01250	N	Anesth, upper leg surgery					
01260	N	Anesth, upper leg veins surg					
01270	N	Anesth, thigh arteries surg					
01272	C	Anesth, femoral artery surg					
01274	C	Anesth, femoral embolectomy					
01300	N	Anesth, skin surgery, knee					
01320	N	Anesth, knee area surgery					
01340	N	Anesth, knee area procedure					
01360	N	Anesth, knee area surgery					
01380	N	Anesth, knee joint procedure					
01382	N	Anesth, knee arthroscopy					
01390	N	Anesth, knee area procedure					
01392	N	Anesth, knee area surgery					
01400	N	Anesth, knee joint surgery					
01402	C	Anesth, replacement of knee					
01404	C	Anesth, amputation at knee					
01420	N	Anesth, knee joint casting					
01430	N	Anesth, knee veins surgery					
01432	N	Anesth, knee vessel surg					
01440	N	Anesth, knee arteries surg					
01442	C	Anesth, knee artery surg					
01444	C	Anesth, knee artery repair					
01460	N	Anesth, lower leg skin surg					
01462	N	Anesth, lower leg procedure					
01464	N	Anesth, ankle arthroscopy					
01470	N	Anesth, lower leg surgery					
01472	N	Anesth, achilles tendon surg					
01474	N	Anesth, lower leg surgery					
01480	N	Anesth, lower leg bone surg					
01482	N	Anesth, radical leg surgery					
01484	N	Anesth, lower leg revision					
01486	C	Anesth, ankle replacement					
01490	N	Anesth, lower leg casting					
01500	N	Anesth, leg arteries surg					
01502	C	Anesth, lowerleg embolectomy					
01520	N	Anesth, lower leg vein surg					
01522	N	Anesth, lower leg vein surg					
01600	N	Anesth, shoulder skin surg					
01610	N	Anesth, surgery of shoulder					
01620	N	Anesth, shoulder procedure					
01622	N	Anesth, shoulder arthroscopy					
01630	N	Anesth, surgery of shoulder					
01632	C	Anesth, surgery of shoulder					
01634	C	Anesth, shoulder joint amput					
01636	C	Anesth, forequarter amput					
01638	C	Anesth, shoulder replacement					
01650	N	Anesth, shoulder artery surg					
01652	C	Anesth, shoulder vessel surg					
01654	C	Anesth, shoulder vessel surg					
01656	C	Anesth, arm-leg vessel surg					
01670	N	Anesth, shoulder vein surg					
01680	N	Anesth, shoulder casting					
01682	N	Anesth, airplane cast					
01700	N	Anesth, elbow area skin surg					
01710	N	Anesth, elbow area surgery					
01712	N	Anesth, upperarm tendon surg					
01714	N	Anesth, upperarm tendon surg					
01716	N	Anesth, biceps tendon repair					
01730	N	Anesth, upperarm procedure					
01732	N	Anesth, elbow arthroscopy					
01740	N	Anesth, upper arm surgery					
01742	N	Anesth, humerus surgery					
01744	N	Anesth, humerus repair					
01756	C	Anesth, radical humerus surg					
01758	N	Anesth, humeral lesion surg					
01760	N	Anesth, elbow replacement					
01770	N	Anesth, upperarm artery surg					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
01772	C	Anesth, upperarm embolectomy	.....	.....	.....	.....	.....
01780	N	Anesth, upper arm vein surg	.....	.....	.....	.....	.....
01782	C	Anesth, upperarm vein repair	.....	.....	.....	.....	.....
01784	N	Anesth, av fistula repair	.....	.....	.....	.....	.....
01800	N	Anesth, lower arm skin surg	.....	.....	.....	.....	.....
01810	N	Anesth, lower arm surgery	.....	.....	.....	.....	.....
01820	N	Anesth, lower arm procedure	.....	.....	.....	.....	.....
01830	N	Anesth, lower arm surgery	.....	.....	.....	.....	.....
01832	N	Anesth, wrist replacement	.....	.....	.....	.....	.....
01840	N	Anesth, lowerarm artery surg	.....	.....	.....	.....	.....
01842	C	Anesth, lowerarm embolectomy	.....	.....	.....	.....	.....
01844	N	Anesth, vascular shunt surg	.....	.....	.....	.....	.....
01850	N	Anesth, lower arm vein surg	.....	.....	.....	.....	.....
01852	C	Anesth, lowerarm vein repair	.....	.....	.....	.....	.....
01860	N	Anesth, lower arm casting	.....	.....	.....	.....	.....
01900	N	Anesth, uterus/tube inject	.....	.....	.....	.....	.....
01902	C	Anesth, burr holes, skull	.....	.....	.....	.....	.....
01904	C	Anesth, skull x-ray inject	.....	.....	.....	.....	.....
01906	N	Anesth, lumbar myelography	.....	.....	.....	.....	.....
01908	N	Anesth, cervical myelography	.....	.....	.....	.....	.....
01910	N	Anesth, skull myelography	.....	.....	.....	.....	.....
01912	N	Anesth, lumbar discography	.....	.....	.....	.....	.....
01914	N	Anesth, cervical discography	.....	.....	.....	.....	.....
01916	C	Anesth, head arteriogram	.....	.....	.....	.....	.....
01918	C	Anesth, limb arteriogram	.....	.....	.....	.....	.....
01920	N	Anesth, catheterize heart	.....	.....	.....	.....	.....
01921	C	Anesth, vessel surgery	.....	.....	.....	.....	.....
01922	N	Anesth, cat or MRI scan	.....	.....	.....	.....	.....
01990	C	Support for organ donor	.....	.....	.....	.....	.....
01995	N	Regional anesthesia, limb	.....	.....	.....	.....	.....
01996	N	Manage daily drug therapy	.....	.....	.....	.....	.....
01999	N	Unlisted anesth procedure	.....	.....	.....	.....	.....
10040	T	Acne surgery of skin abscess	131	1.94	$102.84	$36.61	$20.57
10060	T	Drainage of skin abscess	131	1.94	$102.84	$36.61	$20.57
10061	T	Drainage of skin abscess	131	1.94	$102.84	$36.61	$20.57
10080	T	Drainage of pilonidal cyst	131	1.94	$102.84	$36.61	$20.57
10081	T	Drainage of pilonidal cyst	131	1.94	$102.84	$36.61	$20.57
10120	T	Remove foreign body	131	1.94	$102.84	$36.61	$20.57
10121	T	Remove foreign body	163	10.69	$565.14	$264.65	$113.03
10140	T	Drainage of hematoma/fluid	131	1.94	$102.84	$36.61	$20.57
10160	T	Puncture drainage of lesion	131	1.94	$102.84	$36.61	$20.57
10180	T	Complex drainage, wound	131	1.94	$102.84	$36.61	$20.57
11000	T	Debride infected skin	151	1.74	$92.07	$35.71	$18.41
11001	T	Debride infect skin add	151	1.74	$92.07	$35.71	$18.41
11010	T	Debride skin, fx	163	10.69	$565.14	$264.65	$113.03
11011	T	Debride skin/muscle, fx	163	10.69	$565.14	$264.65	$113.03
11012	T	Debride skin/muscle/bone, fx	163	10.69	$565.14	$264.65	$113.03
11040	T	Debride skin partial	151	1.74	$92.07	$35.71	$18.41
11041	T	Debride skin full	151	1.74	$92.07	$35.71	$18.41
11042	T	Debride skin/tissue	151	1.74	$92.07	$35.71	$18.41
11043	T	Debride tissue/muscle	162	5.67	$299.71	$125.43	$59.94
11044	T	Debride tissue/muscle/bone	162	5.67	$299.71	$125.43	$59.94
11055	T	Trim skin lesion	151	1.74	$92.07	$35.71	$18.41
11056	T	Trim 2 to 4 skin lesions	151	1.74	$92.07	$35.71	$18.41
11057	T	Trim over 4 skin lesions	151	1.74	$92.07	$35.71	$18.41
11100	T	Biopsy of skin lesion	161	3.50	$185.12	$75.48	$37.02
11101	T	Biopsy, each added lesion	161	3.50	$185.12	$75.48	$37.02
11200	T	Removal of skin tags	151	1.74	$92.07	$35.71	$18.41
11201	T	Removal of added skin tags	151	1.74	$92.07	$35.71	$18.41
11300	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11301	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11302	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11303	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11305	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11306	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11307	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11308	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11310	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11311	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11312	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11313	T	Shave skin lesion	151	1.74	$92.07	$35.71	$18.41
11400	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11401	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11402	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11403	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
11404	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11406	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11420	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11421	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11422	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11423	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11424	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11426	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11440	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11441	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11442	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11443	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11444	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11446	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11450	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11451	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11462	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11463	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11470	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11471	T	Removal, sweat gland lesion	163	10.69	$565.14	$264.65	$113.03
11600	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11601	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11602	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11603	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11604	T	Removal of skin lesion	162	5.67	$299.71	$125.43	$59.94
11606	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11620	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11621	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11622	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11623	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11624	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11626	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11640	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11641	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11642	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11643	T	Removal of skin lesion	161	3.50	$185.12	$75.48	$37.02
11644	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11646	T	Removal of skin lesion	163	10.69	$565.14	$264.65	$113.03
11719	T	Trim nail(s)	137	0.46	$24.49	$4.90	$4.90
11720	T	Debride nail, 1–5	137	0.46	$24.49	$4.90	$4.90
11721	T	Debride nail, 6 or more	137	0.46	$24.49	$4.90	$4.90
11730	T	Removal of nail plate	151	1.74	$92.07	$35.71	$18.41
11731	T	Removal of second nail plate	151	1.74	$92.07	$35.71	$18.41
11732	T	Remove additional nail plate	151	1.74	$92.07	$35.71	$18.41
11740	T	Drain blood from under nail	137	0.46	$24.49	$4.90	$4.90
11750	T	Removal of nail bed	161	3.50	$185.12	$75.48	$37.02
11752	T	Remove nail bed/finger tip	163	10.69	$565.14	$264.65	$113.03
11755	T	Biopsy, nail unit	137	0.46	$24.49	$4.90	$4.90
11760	T	Reconstruction of nail bed	181	2.19	$115.58	$43.84	$23.12
11762	T	Reconstruction of nail bed	181	2.19	$115.58	$43.84	$23.12
11765	T	Excision of nail fold, toe	151	1.74	$92.07	$35.71	$18.41
11770	T	Removal of pilonidal lesion	162	5.67	$299.71	$125.43	$59.94
11771	T	Removal of pilonidal lesion	163	10.69	$565.14	$264.65	$113.03
11772	T	Removal of pilonidal lesion	163	10.69	$565.14	$264.65	$113.03
11900	T	Injection into skin lesions	151	1.74	$92.07	$35.71	$18.41
11901	T	Added skin lesions injection	151	1.74	$92.07	$35.71	$18.41
11920	T	Correct skin color defects	181	2.19	$115.58	$43.84	$23.12
11921	T	Correct skin color defects	181	2.19	$115.58	$43.84	$23.12
11922	T	Correct skin color defects	181	2.19	$115.58	$43.84	$23.12
11950	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11951	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11952	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11954	T	Therapy for contour defects	181	2.19	$115.58	$43.84	$23.12
11960	T	Insert tissue expander(s)	183	11.17	$590.61	$286.57	$118.12
11970	T	Replace tissue expander	183	11.17	$590.61	$286.57	$118.12
11971	T	Remove tissue expander(s)	163	10.69	$565.14	$264.65	$113.03
11975	E	Insert contraceptive cap	.....	.....	.....	.....	.....
11976	T	Removal of contraceptive cap	131	1.94	$102.84	$36.61	$20.57
11977	E	Removal/reinsert contra cap	.....	.....	.....	.....	.....
12001	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12002	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12004	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12005	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12006	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12007	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
12011	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12013	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12014	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12015	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12016	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12017	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12018	T	Repair superficial wound(s)	181	2.19	$115.58	$43.84	$23.12
12020	T	Closure of split wound	181	2.19	$115.58	$43.84	$23.12
12021	T	Closure of split wound	181	2.19	$115.58	$43.84	$23.12
12031	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12032	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12034	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12035	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12036	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12037	T	Layer closure of wound(s)	183	11.17	$590.61	$286.57	$118.12
12041	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12042	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12044	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12045	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12046	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12047	T	Layer closure of wound(s)	183	11.17	$590.61	$286.57	$118.12
12051	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12052	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12053	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12054	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12055	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12056	T	Layer closure of wound(s)	181	2.19	$115.58	$43.84	$23.12
12057	T	Layer closure of wound(s)	183	11.17	$590.61	$286.57	$118.12
13100	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13101	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13120	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13121	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13131	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13132	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13150	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13151	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13152	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
13160	T	Late closure of wound	182	4.00	$211.56	$84.98	$42.31
13300	T	Repair of wound or lesion	182	4.00	$211.56	$84.98	$42.31
14000	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14001	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14020	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14021	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14040	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14041	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14060	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14061	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14300	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
14350	T	Skin tissue rearrangement	183	11.17	$590.61	$286.57	$118.12
15000	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15050	T	Skin pinch graft procedure	183	11.17	$590.61	$286.57	$118.12
15100	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15101	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15120	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15121	T	Skin split graft procedure	183	11.17	$590.61	$286.57	$118.12
15200	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15201	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15220	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15221	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15240	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15241	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15260	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15261	T	Skin full graft procedure	183	11.17	$590.61	$286.57	$118.12
15350	T	Skin homograft procedure	183	11.17	$590.61	$286.57	$118.12
15400	T	Skin heterograft procedure	183	11.17	$590.61	$286.57	$118.12
15570	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15572	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15574	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15576	T	Form skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15580	T	Attach skin pedicle graft	183	11.17	$590.61	$286.57	$118.12
15600	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15610	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15620	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15625	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12
15630	T	Skin graft procedure	183	11.17	$590.61	$286.57	$118.12

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
15650	T	Transfer skin pedicle flap	183	11.17	$590.61	$286.57	$118.12
15732	T	Muscle-skin graft, head/neck	184	15.17	$802.17	$396.40	$160.43
15734	T	Muscle-skin graft, trunk	184	15.17	$802.17	$396.40	$160.43
15736	T	Muscle-skin graft, arm	184	15.17	$802.17	$396.40	$160.43
15738	T	Muscle-skin graft, leg	184	15.17	$802.17	$396.40	$160.43
15740	T	Island pedicle flap graft	184	15.17	$802.17	$396.40	$160.43
15750	T	Neurovascular pedicle graft	184	15.17	$802.17	$396.40	$160.43
15756	C	Free muscle flap, microvasc	.....	.....	.....	.....	.....
15757	C	Free skin flap, microvasc	.....	.....	.....	.....	.....
15758	C	Free fascial flap, microvasc	.....	.....	.....	.....	.....
15760	T	Composite skin graft	184	15.17	$802.17	$396.40	$160.43
15770	T	Derma-fat-fascia graft	184	15.17	$802.17	$396.40	$160.43
15775	T	Hair transplant punch grafts	183	11.17	$590.61	$286.57	$118.12
15776	T	Hair transplant punch grafts	183	11.17	$590.61	$286.57	$118.12
15780	T	Abrasion treatment of skin	163	10.69	$565.14	$264.65	$113.03
15781	T	Abrasion treatment of skin	163	10.69	$565.14	$264.65	$113.03
15782	T	Abrasion treatment of skin	163	10.69	$565.14	$264.65	$113.03
15783	T	Abrasion treatment of skin	151	1.74	$92.07	$35.71	$18.41
15786	T	Abrasion treatment of lesion	151	1.74	$92.07	$35.71	$18.41
15787	T	Abrasion, added skin lesions	151	1.74	$92.07	$35.71	$18.41
15788	T	Chemical peel, face, epiderm	151	1.74	$92.07	$35.71	$18.41
15789	T	Chemical peel, face, dermal	151	1.74	$92.07	$35.71	$18.41
15792	T	Chemical peel, nonfacial	151	1.74	$92.07	$35.71	$18.41
15793	T	Chemical peel, nonfacial	151	1.74	$92.07	$35.71	$18.41
15810	T	Salabrasion	151	1.74	$92.07	$35.71	$18.41
15811	T	Salabrasion	163	10.69	$565.14	$264.65	$113.03
15819	T	Plastic surgery, neck	183	11.17	$590.61	$286.57	$118.12
15820	T	Revision of lower eyelid	183	11.17	$590.61	$286.57	$118.12
15821	T	Revision of lower eyelid	183	11.17	$590.61	$286.57	$118.12
15822	T	Revision of upper eyelid	183	11.17	$590.61	$286.57	$118.12
15823	T	Revision of upper eyelid	183	11.17	$590.61	$286.57	$118.12
15824	T	Removal of forehead wrinkles	184	15.17	$802.17	$396.40	$160.43
15825	T	Removal of neck wrinkles	183	11.17	$590.61	$286.57	$118.12
15826	T	Removal of brow wrinkles	184	15.17	$802.17	$396.40	$160.43
15828	T	Removal of face wrinkles	184	15.17	$802.17	$396.40	$160.43
15829	T	Removal of skin wrinkles	183	11.17	$590.61	$286.57	$118.12
15831	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15832	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15833	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15834	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15835	T	Excise excessive skin tissue	183	11.17	$590.61	$286.57	$118.12
15836	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15837	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15838	T	Excise excessive skin tissue	163	10.69	$565.14	$264.65	$113.03
15839	T	Excise excessive skin tissue	184	15.17	$802.17	$396.40	$160.43
15840	T	Graft for face nerve palsy	184	15.17	$802.17	$396.40	$160.43
15841	T	Graft for face nerve palsy	184	15.17	$802.17	$396.40	$160.43
15842	T	Graft for face nerve palsy	184	15.17	$802.17	$396.40	$160.43
15845	T	Skin and muscle repair, face	184	15.17	$802.17	$396.40	$160.43
15850	T	Removal of sutures	151	1.74	$92.07	$35.71	$18.41
15851	T	Removal of sutures	151	1.74	$92.07	$35.71	$18.41
15852	T	Dressing change, not for burn	151	1.74	$92.07	$35.71	$18.41
15860	N	Test for blood flow in graft	.....	.....	.....	.....	.....
15876	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15877	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15878	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15879	T	Suction assisted lipectomy	184	15.17	$802.17	$396.40	$160.43
15920	T	Removal of tail bone ulcer	163	10.69	$565.14	$264.65	$113.03
15922	T	Removal of tail bone ulcer	184	15.17	$802.17	$396.40	$160.43
15931	T	Remove sacrum pressure sore	163	10.69	$565.14	$264.65	$113.03
15933	T	Remove sacrum pressure sore	163	10.69	$565.14	$264.65	$113.03
15934	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15935	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15936	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15937	T	Remove sacrum pressure sore	184	15.17	$802.17	$396.40	$160.43
15940	T	Removal of pressure sore	163	10.69	$565.14	$264.65	$113.03
15941	T	Removal of pressure sore	163	10.69	$565.14	$264.65	$113.03
15944	T	Removal of pressure sore	184	15.17	$802.17	$396.40	$160.43
15945	T	Removal of pressure sore	184	15.17	$802.17	$396.40	$160.43
15946	T	Removal of pressure sore	184	15.17	$802.17	$396.40	$160.43
15950	T	Remove thigh pressure sore	163	10.69	$565.14	$264.65	$113.03
15951	T	Remove thigh pressure sore	163	10.69	$565.14	$264.65	$113.03
15952	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43
15953	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43
15956	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
15958	T	Remove thigh pressure sore	184	15.17	$802.17	$396.40	$160.43
15999	T	Removal of pressure sore	163	10.69	$565.14	$264.65	$113.03
16000	T	Initial treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16010	T	Treatment of burn(s)	152	10.43	$551.43	$261.71	$110.29
16015	T	Treatment of burn(s)	152	10.43	$551.43	$261.71	$110.29
16020	T	Treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16025	T	Treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16030	T	Treatment of burn(s)	151	1.74	$92.07	$35.71	$18.41
16035	T	Incision of burn scab	162	5.67	$299.71	$125.43	$59.94
16040	T	Burn wound excision	162	5.67	$299.71	$125.43	$59.94
16041	T	Burn wound excision	162	5.67	$299.71	$125.43	$59.94
16042	T	Burn wound excision	162	5.67	$299.71	$125.43	$59.94
17000	T	Destroy benign/premal lesion	141	0.59	$31.34	$9.49	$6.27
17003	T	Destroy 2–14 lesions	141	0.59	$31.34	$9.49	$6.27
17004	T	Destroy 15 & more lesions	142	3.78	$199.81	$73.00	$39.96
17106	T	Destruction of skin lesions	141	0.59	$31.34	$9.49	$6.27
17107	T	Destruction of skin lesions	142	3.78	$199.81	$73.00	$39.96
17108	T	Destruction of skin lesions	142	3.78	$199.81	$73.00	$39.96
17110	T	Destruct lesion, 1–14	141	0.59	$31.34	$9.49	$6.27
17111	T	Destruct lesion, 15 or more	142	3.78	$199.81	$73.00	$39.96
17250	T	Chemical cautery, tissue	151	1.74	$92.07	$35.71	$18.41
17260	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17261	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17262	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17263	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17264	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17266	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17270	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17271	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17272	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17273	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17274	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17276	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17280	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17281	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17282	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17283	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17284	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17286	T	Destruction of skin lesions	151	1.74	$92.07	$35.71	$18.41
17304	T	Chemosurgery of skin lesion	162	5.67	$299.71	$125.43	$59.94
17305	T	2nd stage chemosurgery	162	5.67	$299.71	$125.43	$59.94
17306	T	3rd stage chemosurgery	162	5.67	$299.71	$125.43	$59.94
17307	T	Followup skin lesion therapy	162	5.67	$299.71	$125.43	$59.94
17310	T	Extensive skin chemosurgery	162	5.67	$299.71	$125.43	$59.94
17340	T	Cryotherapy of skin	151	1.74	$92.07	$35.71	$18.41
17360	T	Skin peel therapy	151	1.74	$92.07	$35.71	$18.41
17380	T	Hair removal by electrolysis	151	1.74	$92.07	$35.71	$18.41
17999	T	Skin tissue procedure	121	0.67	$35.26	$21.02	$7.05
19000	T	Drainage of breast lesion	121	0.67	$35.26	$21.02	$7.05
19001	T	Drain added breast lesion	121	0.67	$35.26	$21.02	$7.05
19020	T	Incision of breast lesion	132	6.04	$319.30	$134.24	$63.86
19030	T	Injection for breast x-ray	347	2.93	$154.75	$62.15	$30.95
19100	T	Biopsy of breast	122	4.87	$257.60	$115.03	$51.52
19101	T	Biopsy of breast	197	12.13	$641.54	$310.75	$128.31
19110	T	Nipple exploration	197	12.13	$641.54	$310.75	$128.31
19112	T	Excise breast duct fistula	197	12.13	$641.54	$310.75	$128.31
19120	T	Removal of breast lesion	197	12.13	$641.54	$310.75	$128.31
19125	T	Excision, breast lesion	197	12.13	$641.54	$310.75	$128.31
19126	T	Excision, add'l breast lesion	197	12.13	$641.54	$310.75	$128.31
19140	T	Removal of breast tissue	197	12.13	$641.54	$310.75	$128.31
19160	T	Removal of breast tissue	198	19.17	$1,013.73	$530.20	$202.75
19162	T	Remove breast tissue, nodes	198	19.17	$1,013.73	$530.20	$202.75
19180	T	Removal of breast	198	19.17	$1,013.73	$530.20	$202.75
19182	T	Removal of breast	198	19.17	$1,013.73	$530.20	$202.75
19200	C	Removal of breast	.....	.....	.....	.....	.....
19220	C	Removal of breast	.....	.....	.....	.....	.....
19240	C	Removal of breast	.....	.....	.....	.....	.....
19260	C	Removal of chest wall lesion	.....	.....	.....	.....	.....
19271	C	Revision of chest wall	.....	.....	.....	.....	.....
19272	C	Extensive chest wall surgery	.....	.....	.....	.....	.....
19290	T	Place needle wire, breast	197	12.13	$641.54	$310.75	$128.31
19291	T	Place needle wire, breast	197	12.13	$641.54	$310.75	$128.31
19316	T	Suspension of breast	198	19.17	$1,013.73	$530.20	$202.75
19318	T	Reduction of large breast	198	19.17	$1,013.73	$530.20	$202.75
19324	T	Enlarge breast	198	19.17	$1,013.73	$530.20	$202.75

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
19325	T	Enlarge breast with implant	198	19.17	$1,013.73	$530.20	$202.75
19328	T	Removal of breast implant	198	19.17	$1,013.73	$530.20	$202.75
19330	T	Removal of implant material	198	19.17	$1,013.73	$530.20	$202.75
19340	T	Immediate breast prosthesis	198	19.17	$1,013.73	$530.20	$202.75
19342	T	Delayed breast prosthesis	198	19.17	$1,013.73	$530.20	$202.75
19350	T	Breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19355	T	Correct inverted nipple(s)	198	19.17	$1,013.73	$530.20	$202.75
19357	T	Breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	198	19.17	$1,013.73	$530.20	$202.75
19371	T	Removal of breast capsule	198	19.17	$1,013.73	$530.20	$202.75
19380	T	Revise breast reconstruction	198	19.17	$1,013.73	$530.20	$202.75
19396	T	Design custom breast implant	197	12.13	$641.54	$310.75	$128.31
19499	T	Breast surgery procedure	197	12.13	$641.54	$310.75	$128.31
20000	T	Incision of abscess	131	1.94	$102.84	$36.61	$20.57
20005	T	Incision of deep abscess	251	14.26	$754.18	$366.12	$150.84
20100	C	Explore wound, neck					
20101	C	Explore wound, chest					
20102	C	Explore wound, abdomen					
20103	C	Explore wound, extremity					
20150	C	Excise epiphyseal bar					
20200	T	Muscle biopsy	162	5.67	$299.71	$125.43	$59.94
20205	T	Deep muscle biopsy	162	5.67	$299.71	$125.43	$59.94
20206	T	Needle biopsy, muscle	122	4.87	$257.6	$115.03	$51.52
20220	T	Bone biopsy, trocar/needle	162	5.67	$299.71	$125.43	$59.94
20225	T	Bone biopsy, trocar/needle	162	5.67	$299.71	$125.43	$59.94
20240	T	Bone biopsy, excisional	163	10.69	$565.14	$264.65	$113.03
20245	T	Bone biopsy, excisional	163	10.69	$565.14	$264.65	$113.03
20250	T	Open bone biopsy	251	14.26	$754.18	$366.12	$150.84
20251	T	Open bone biopsy	251	14.26	$754.18	$366.12	$150.84
20500	T	Injection of sinus tract	181	2.19	$115.58	$43.84	$23.12
20501	T	Inject sinus tract for x-ray	347	2.93	$154.75	$62.15	$30.95
20520	T	Removal of foreign body	161	3.50	$185.12	$75.48	$37.02
20525	T	Removal of foreign body	163	10.69	$565.14	$264.65	$113.03
20550	T	Inj tendon/ligament/cyst	200	1.89	$99.90	$39.10	$19.98
20600	T	Drain/inject joint/bursa	200	1.89	$99.90	$39.10	$19.98
20605	T	Drain/inject joint/bursa	200	1.89	$99.90	$39.10	$19.98
20610	T	Drain/inject joint/bursa	200	1.89	$99.90	$39.10	$19.98
20615	T	Treatment of bone cyst	121	0.67	$35.26	$21.02	$7.05
20650	T	Insert and remove bone pin	251	14.26	$754.18	$366.12	$150.84
20660	C	Apply,remove fixation device					
20661	C	Application of head brace					
20662	C	Application of pelvis brace					
20663	C	Application of thigh brace					
20664	C	Halo brace application					
20665	N	Removal of fixation device					
20670	T	Removal of support implant	162	5.67	$299.71	$125.43	$59.94
20680	T	Removal of support implant	163	10.69	$565.14	$264.65	$113.03
20690	T	Apply bone fixation device	252	19.39	$1,025.49	$509.18	$205.10
20692	T	Apply bone fixation device	252	19.39	$1,025.49	$509.18	$205.10
20693	T	Adjust bone fixation device	251	14.26	$754.18	$366.12	$150.84
20694	T	Remove bone fixation device	251	14.26	$754.18	$366.12	$150.84
20802	C	Replantation, arm, complete					
20805	C	Replant forearm, complete					
20808	C	Replantation, hand, complete					
20816	C	Replantation digit, complete					
20822	C	Replantation digit, complete					
20824	C	Replantation thumb, complete					
20827	C	Replantation thumb, complete					
20838	C	Replantation, foot, complete					
20900	T	Removal of bone for graft	252	19.39	$1,025.49	$509.18	$205.10
20902	T	Removal of bone for graft	252	19.39	$1,025.49	$509.18	$205.10
20910	T	Remove cartilage for graft	183	11.17	$590.61	$286.57	$118.12
20912	T	Remove cartilage for graft	183	11.17	$590.61	$286.57	$118.12
20920	T	Removal of fascia for graft	183	11.17	$590.61	$286.57	$118.12
20922	T	Removal of fascia for graft	183	11.17	$590.61	$286.57	$118.12
20924	T	Removal of tendon for graft	252	19.39	$1,025.49	$509.18	$205.10
20926	T	Removal of tissue for graft	183	11.17	$590.61	$286.57	$118.12
20930	C	Spinal bone allograft					
20931	C	Spinal bone allograft					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
20936	C	Spinal bone autograft	.....	.....	.....	.....	.....
20937	C	Spinal bone autograft	.....	.....	.....	.....	.....
20938	C	Spinal bone autograft	.....	.....	.....	.....	.....
20950	T	Record fluid pressure,muscle	132	6.04	$319.30	$134.24	$63.86
20955	C	Fibula bone graft, microvasc	.....	.....	.....	.....	.....
20956	C	Iliac bone graft, microvasc	.....	.....	.....	.....	.....
20957	C	Mt bone graft, microvasc	.....	.....	.....	.....	.....
20962	C	Other bone graft, microvasc	.....	.....	.....	.....	.....
20969	C	Bone/skin graft, microvasc	.....	.....	.....	.....	.....
20970	C	Bone/skin graft, iliac crest	.....	.....	.....	.....	.....
20972	C	Bone-skin graft, metatarsal	.....	.....	.....	.....	.....
20973	C	Bone-skin graft, great toe	.....	.....	.....	.....	.....
20974	A	Electrical bone stimulation	.....	.....	.....	.....	.....
20975	T	Electrical bone stimulation	251	14.26	$754.18	$366.12	$150.84
20999	N	Musculoskeletal surgery	.....	.....	.....	.....	.....
21010	T	Incision of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21015	T	Resection of facial tumor	231	12.02	$635.66	299.90	$127.13
21025	T	Excision of bone, lower jaw	231	12.02	$635.66	299.90	$127.13
21026	T	Excision of facial bone(s)	231	12.02	$635.66	299.90	$127.13
21029	T	Contour of face bone lesion	231	12.02	$635.66	299.90	$127.13
21030	T	Removal of face bone lesion	231	12.02	$635.66	299.90	$127.13
21031	T	Remove exostosis, mandible	231	12.02	$635.66	299.90	$127.13
21032	T	Remove exostosis, maxilla	231	12.02	$635.66	299.90	$127.13
21034	T	Removal of face bone lesion	232	23.93	$1,265.45	$639.35	$253.09
21040	T	Removal of jaw bone lesion	231	12.02	$635.66	299.90	$127.13
21041	T	Removal of jaw bone lesion	231	12.02	$635.66	299.90	$127.13
21044	T	Removal of jaw bone lesion	232	23.93	$1,265.45	$639.35	$253.09
21045	C	Extensive jaw surgery	.....	.....	.....	.....	.....
21050	T	Removal of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21060	T	Remove jaw joint cartilage	232	23.93	$1,265.45	$639.35	$253.09
21070	T	Remove coronoid process	232	23.93	$1,265.45	$639.35	$253.09
21076	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21077	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21079	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21080	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21081	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21082	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21083	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21084	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21085	N	Prepare face/oral prosthesis	.....	.....	.....	.....	.....
21086	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21087	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21088	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21089	T	Prepare face/oral prosthesis	226	1.59	$84.23	$21.92	$16.85
21100	T	Maxillofacial fixation	231	12.02	$635.66	299.90	$127.13
21110	T	Interdental fixation	231	12.02	$635.66	299.90	$127.13
21116	T	Injection, jaw joint x-ray	347	2.93	$154.75	$62.15	$30.95
21120	T	Reconstruction of chin	231	12.02	$635.66	299.90	$127.13
21121	T	Reconstruction of chin	232	23.93	$1,265.45	$639.35	$253.09
21122	T	Reconstruction of chin	232	23.93	$1,265.45	$639.35	$253.09
21123	T	Reconstruction of chin	232	23.93	$1,265.45	$639.35	$253.09
21125	T	Augmentation lower jaw bone	231	12.02	$635.66	299.90	$127.13
21127	T	Augmentation lower jaw bone	232	23.93	$1,265.45	$639.35	$253.09
21137	C	Reduction of forehead	.....	.....	.....	.....	.....
21138	C	Reduction of forehead	.....	.....	.....	.....	.....
21139	C	Reduction of forehead	.....	.....	.....	.....	.....
21141	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21142	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21143	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21145	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21146	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21147	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21150	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21151	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21154	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21155	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21159	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21160	C	Reconstruct midface, lefort	.....	.....	.....	.....	.....
21172	C	Reconstruct orbit/forehead	.....	.....	.....	.....	.....
21175	C	Reconstruct orbit/forehead	.....	.....	.....	.....	.....
21179	C	Reconstruct entire forehead	.....	.....	.....	.....	.....
21180	C	Reconstruct entire forehead	.....	.....	.....	.....	.....
21181	T	Contour cranial bone lesion	232	23.93	$1,265.45	$639.35	$253.09
21182	C	Reconstruct cranial bone	.....	.....	.....	.....	.....
21183	C	Reconstruct cranial bone	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
21184	C	Reconstruct cranial bone					
21188	C	Reconstruction of midface					
21193	C	Reconstruct lower jaw bone					
21194	C	Reconstruct lower jaw bone					
21195	C	Reconstruct lower jaw bone					
21196	C	Reconstruct lower jaw bone					
21198	C	Reconstruct lower jaw bone					
21206	T	Reconstruct upper jaw bone	232	23.93	$1,265.45	$639.35	$253.09
21208	T	Augmentation of facial bones	232	23.93	$1,265.45	$639.35	$253.09
21209	T	Reduction of facial bones	232	23.93	$1,265.45	$639.35	$253.09
21210	T	Face bone graft	232	23.93	$1,265.45	$639.35	$253.09
21215	T	Lower jaw bone graft	232	23.93	$1,265.45	$639.35	$253.09
21230	T	Rib cartilage graft	232	23.93	$1,265.45	$639.35	$253.09
21235	T	Ear cartilage graft	232	23.93	$1,265.45	$639.35	$253.09
21240	T	Reconstruction of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21242	T	Reconstruction of jaw joint	232	23.93	$1,265.45	$639.35	$253.09
21243	T	Reconstruction of jaw joint	218	27.50	$1,454.49	$715.52	$290.90
21244	T	Reconstruction of lower jaw	232	23.93	$1,265.45	$639.35	$253.09
21245	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21246	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21249	T	Reconstruction of jaw	232	23.93	$1,265.45	$639.35	$253.09
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	232	23.93	$1,265.45	$639.35	$253.09
21261	C	Revise eye sockets					
21263	C	Revise eye sockets					
21267	T	Revise eye sockets	232	23.93	$1,265.45	$639.35	$253.09
21268	C	Revise eye sockets					
21270	T	Augmentation cheek bone	232	23.93	$1,265.45	$639.35	$253.09
21275	T	Revision orbitofacial bones	232	23.93	$1,265.45	$639.35	$253.09
21280	T	Revision of eyelid	231	12.02	$635.66	$299.90	$127.13
21282	T	Revision of eyelid	231	12.02	$635.66	$299.90	$127.13
21295	T	Revision of jaw muscle/bone	231	12.02	$635.66	$299.90	$127.13
21296	T	Revision of jaw muscle/bone	231	12.02	$635.66	$299.90	$127.13
21299	T	Cranio/maxillofacial surgery	231	12.02	$635.66	$299.90	$127.13
21300	T	Treatment of skull fracture	231	12.02	$635.66	$299.90	$127.13
21310	T	Treatment of nose fracture	231	12.02	$635.66	$299.90	$127.13
21315	T	Treatment of nose fracture	231	12.02	$635.66	$299.90	$127.13
21320	T	Treatment of nose fracture	231	12.02	$635.66	$299.90	$127.13
21325	T	Repair of nose fracture	231	12.02	$635.66	$299.90	$127.13
21330	T	Repair of nose fracture	232	23.93	$1,265.45	$639.35	$253.09
21335	T	Repair of nose fracture	232	23.93	$1,265.45	$639.35	$253.09
21336	T	Repair nasal septal fracture	216	20.13	$1,064.67	$520.93	$212.93
21337	T	Repair nasal septal fracture	231	12.02	$635.66	$299.90	$127.13
21338	T	Repair nasoethmoid fracture	232	23.93	$1,265.45	$639.35	$253.09
21339	T	Repair nasoethmoid fracture	232	23.93	$1,265.45	$639.35	$253.09
21340	T	Repair of nose fracture	232	23.93	$1,265.45	$639.35	$253.09
21343	T	Repair of sinus fracture	232	23.93	$1,265.45	$639.35	$253.09
21344	C	Repair of sinus fracture					
21345	T	Repair of nose/jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21346	C	Repair of nose/jaw fracture					
21347	C	Repair of nose/jaw fracture					
21348	C	Repair of nose/jaw fracture					
21355	T	Repair cheek bone fracture	231	12.02	$635.66	$299.90	$127.13
21356	C	Repair cheek bone fracture					
21360	C	Repair cheek bone fracture					
21365	C	Repair cheek bone fracture					
21366	C	Repair cheek bone fracture					
21385	C	Repair eye socket fracture					
21386	C	Repair eye socket fracture					
21387	C	Repair eye socket fracture					
21390	C	Repair eye socket fracture					
21395	C	Repair eye socket fracture					
21400	T	Treat eye socket fracture	231	12.02	$635.66	$299.90	$127.13
21401	T	Repair eye socket fracture	231	12.02	$635.66	$299.90	$127.13
21406	C	Repair eye socket fracture					
21407	C	Repair eye socket fracture					
21408	C	Repair eye socket fracture					
21421	T	Treat mouth roof fracture	232	23.93	$1,265.45	$639.35	$253.09
21422	C	Repair mouth roof fracture					
21423	C	Repair mouth roof fracture					
21431	C	Treat craniofacial fracture					
21432	C	Repair craniofacial fracture					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
21433	C	Repair craniofacial fracture					
21435	C	Repair craniofacial fracture					
21436	C	Repair craniofacial fracture					
21440	T	Repair dental ridge fracture	231	12.02	$635.66	$299.90	$127.13
21445	T	Repair dental ridge fracture	232	23.93	$1,265.45	$639.35	$253.09
21450	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21451	T	Treat lower jaw fracture	231	12.02	$635.66	$299.90	$127.13
21452	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21453	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21454	T	Treat lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21461	T	Repair lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21462	T	Repair lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21465	T	Repair lower jaw fracture	232	23.93	$1,265.45	$639.35	$253.09
21470	C	Repair lower jaw fracture					
21480	T	Reset dislocated jaw	231	12.02	$635.66	$299.90	$127.13
21485	T	Reset dislocated jaw	231	12.02	$635.66	$299.90	$127.13
21490	T	Repair dislocated jaw	232	23.93	$1,265.45	$639.35	$253.09
21493	T	Treat hyoid bone fracture	231	12.02	$635.66	$299.90	$127.13
21494	T	Repair hyoid bone fracture	231	12.02	$635.66	$299.90	$127.13
21495	C	Repair hyoid bone fracture					
21497	T	Interdental wiring	231	12.02	$635.66	$299.90	$127.13
21499	T	Head surgery procedure	231	12.02	$635.66	$299.90	$127.13
21501	T	Drain neck/chest lesion	132	6.04	$319.30	$134.24	$63.86
21502	T	Drain chest lesion	252	19.39	$1,025.49	$509.18	$205.10
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	161	3.50	$185.12	$75.48	$37.02
21555	T	Remove lesion neck/chest	163	10.69	$565.14	$264.65	$113.03
21556	T	Remove lesion neck/chest	163	10.69	$565.14	$264.65	$113.03
21557	C	Remove tumor, neck or chest					
21600	T	Partial removal of rib	252	19.39	$1,025.49	$509.18	$205.10
21610	T	Partial removal of rib	252	19.39	$1,025.49	$509.18	$205.10
21615	C	Removal of rib					
21616	C	Removal of rib and nerves					
21620	C	Partial removal of sternum					
21627	C	Sternal debridement					
21630	C	Extensive sternum surgery					
21632	C	Extensive sternum surgery					
21700	T	Revision of neck muscle	132	6.04	$319.30	$134.24	$63.86
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	132	6.04	$319.30	$134.24	$63.86
21725	T	Revision of neck muscle	132	6.04	$319.30	$134.24	$63.86
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	207	1.70	$90.11	$31.64	$18.02
21805	T	Treatment of rib fracture	216	20.13	$1,064.67	$520.93	$212.93
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	207	1.70	$90.11	$31.64	$18.02
21825	C	Repair sternum fracture					
21899	T	Neck/chest surgery procedure	207	1.70	$90.11	$31.64	$18.02
21920	T	Biopsy soft tissue of back	161	3.50	$185.12	$75.48	$37.02
21925	T	Biopsy soft tissue of back	163	10.69	$565.14	$264.65	$113.03
21930	T	Remove lesion, back or flank	163	10.69	$565.14	$264.65	$113.03
21935	T	Remove tumor of back	163	10.69	$565.14	$264.65	$113.03
22100	C	Remove part of neck vertebra					
22101	C	Remove part, thorax vertebra					
22102	C	Remove part, lumbar vertebra					
22103	C	Remove extra spine segment					
22110	C	Remove part of neck vertebra					
22112	C	Remove part, thorax vertebra					
22114	C	Remove part, lumbar vertebra					
22116	C	Remove extra spine segment					
22210	C	Revision of neck spine					
22212	C	Revision of thorax spine					
22214	C	Revision of lumbar spine					
22216	C	Revise, extra spine segment					
22220	C	Revision of neck spine					
22222	C	Revision of thorax spine					
22224	C	Revision of lumbar spine					
22226	C	Revise, extra spine segment					
22305	T	Treat spine process fracture	207	1.70	$90.11	$31.64	$18.02
22310	T	Treat spine fracture	207	1.70	$90.11	$31.64	$18.02
22315	T	Treat spine fracture	207	1.70	$90.11	$31.64	$18.02
22325	C	Repair of spine fracture					
22326	C	Repair neck spine fracture					
22327	C	Repair thorax spine fracture					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
22328	C	Repair each add spine fx					
22505	T	Manipulation of spine	210	10.46	$553.39	$283.4	$110.68
22548	C	Neck spine fusion					
22554	C	Neck spine fusion					
22556	C	Thorax spine fusion					
22558	C	Lumbar spine fusion					
22585	C	Additional spinal fusion					
22590	C	Spine & skull spinal fusion					
22595	C	Neck spinal fusion					
22600	C	Neck spine fusion					
22610	C	Thorax spine fusion					
22612	C	Lumbar spine fusion					
22614	C	Spine fusion, extra segment					
22630	C	Lumbar spine fusion					
22632	C	Spine fusion, extra segment					
22800	C	Fusion of spine					
22802	C	Fusion of spine					
22804	C	Fusion of spine					
22808	C	Fusion of spine					
22810	C	Fusion of spine					
22812	C	Fusion of spine					
22818	C	Kyphectomy, 1–2 segments					
22819	C	Kyphectomy, 3 & more segment					
22830	C	Exploration of spinal fusion					
22840	C	Insert spine fixation device					
22841	C	Insert spine fixation device					
22842	C	Insert spine fixation device					
22843	C	Insert spine fixation device					
22844	C	Insert spine fixation device					
22845	C	Insert spine fixation device					
22846	C	Insert spine fixation device					
22847	C	Insert spine fixation device					
22848	C	Insert pelvic fixation device					
22849	C	Reinsert spinal fixation					
22850	C	Remove spine fixation device					
22851	C	Apply spine prosth device					
22852	C	Remove spine fixation device					
22855	C	Remove spine fixation device					
22899	T	Spine surgery procedure	207	1.70	$90.11	$31.64	$18.02
22900	T	Remove abdominal wall lesion	163	10.69	$565.14	$264.65	$113.03
22999	T	Abdomen surgery procedure	163	10.69	$565.14	$264.65	$113.03
23000	T	Removal of calcium deposits	162	5.67	$299.71	$125.43	$59.94
23020	T	Release shoulder joint	253	26.33	$1,392.78	$699.24	$278.56
23030	T	Drain shoulder lesion	132	6.04	$319.30	$134.24	$63.86
23031	T	Drain shoulder bursa	132	6.04	$319.30	$134.24	$63.86
23035	C	Drain shoulderbone lesion					
23040	T	Exploratory shoulder surgery	252	19.39	$1,025.49	$509.18	$205.10
23044	T	Exploratory shoulder surgery	252	19.39	$1,025.49	$509.18	$205.10
23065	T	Biopsy shoulder tissues	161	3.50	$185.12	$75.48	$37.02
23066	T	Biopsy shoulder tissues	163	10.69	$565.14	$264.65	$113.03
23075	T	Removal of shoulder lesion	162	5.67	$299.71	$125.43	$59.94
23076	T	Removal of shoulder lesion	163	10.69	$565.14	$264.65	$113.03
23077	T	Remove tumor of shoulder	163	10.69	$565.14	$264.65	$113.03
23100	T	Biopsy of shoulder joint	251	14.26	$754.18	$366.12	$150.84
23101	T	Shoulder joint surgery	252	19.39	$1,025.49	$509.18	$205.10
23105	T	Remove shoulder joint lining	252	19.39	$1,025.49	$509.18	$205.10
23106	T	Incision of collarbone joint	252	19.39	$1,025.49	$509.18	$205.10
23107	T	Explore, treat shoulder joint	252	19.39	$1,025.49	$509.18	$205.10
23120	T	Partial removal, collarbone	253	26.33	$1,392.78	$699.24	$278.56
23125	C	Removal of collarbone					
23130	T	Partial removal, shoulderbone	253	26.33	$1,392.78	$699.24	$278.56
23140	T	Removal of bone lesion	251	14.26	$754.18	$366.12	$150.84
23145	T	Removal of bone lesion	252	19.39	$1,025.49	$509.18	$205.10
23146	T	Removal of bone lesion	252	19.39	$1,025.49	$509.18	$205.10
23150	T	Removal of humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23155	T	Removal of humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23156	T	Removal of humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23170	T	Remove collarbone lesion	252	19.39	$1,025.49	$509.18	$205.10
23172	T	Remove shoulder blade lesion	252	19.39	$1,025.49	$509.18	$205.10
23174	T	Remove humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23180	T	Remove collarbone lesion	252	19.39	$1,025.49	$509.18	$205.10
23182	T	Remove shoulderblade lesion	252	19.39	$1,025.49	$509.18	$205.10
23184	T	Remove humerus lesion	252	19.39	$1,025.49	$509.18	$205.10
23190	T	Partial removal of scapula	252	19.39	$1,025.49	$509.18	$205.10
23195	C	Removal of head of humerus					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
23200	C	Removal of collarbone	.....	.....	.....	.....	.....
23210	C	Removal of shoulderblade	.....	.....	.....	.....	.....
23220	C	Partial removal of humerus	.....	.....	.....	.....	.....
23221	C	Partial removal of humerus	.....	.....	.....	.....	.....
23222	C	Partial removal of humerus	.....	.....	.....	.....	.....
23330	T	Remove shoulder foreign body	163	10.69	$565.14	$264.65	$113.03
23331	T	Remove shoulder foreign body	163	10.69	$565.14	$264.65	$113.03
23332	C	Remove shoulder foreign body	.....	.....	.....	.....	.....
23350	T	Injection for shoulder x-ray	347	2.93	$154.75	$62.15	$30.95
23395	C	Muscle transfer, shoulder/arm	.....	.....	.....	.....	.....
23397	C	Muscle transfers	.....	.....	.....	.....	.....
23400	C	Fixation of shoulderblade	.....	.....	.....	.....	.....
23405	T	Incision of tendon & muscle	252	19.39	$1,025.49	$509.18	$205.10
23406	T	Incise tendon(s) & muscle(s)	252	19.39	$1,025.49	$509.18	$205.10
23410	T	Repair of tendon(s)	254	34.37	$1,817.86	$937.22	$363.57
23412	T	Repair of tendon(s)	254	34.37	$1,817.86	$937.22	$363.57
23415	T	Release of shoulder ligament	253	26.33	$1,392.78	$699.24	$278.56
23420	T	Repair of shoulder	254	34.37	$1,817.86	$937.22	$363.57
23430	T	Repair biceps tendon	254	34.37	$1,817.86	$937.22	$363.57
23440	C	Removal/transplant tendon	.....	.....	.....	.....	.....
23450	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23455	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23460	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23462	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23465	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23466	T	Repair shoulder capsule	254	34.37	$1,817.86	$937.22	$363.57
23470	C	Reconstruct shoulder joint	.....	.....	.....	.....	.....
23472	C	Reconstruct shoulder joint	.....	.....	.....	.....	.....
23480	T	Revision of collarbone	253	26.33	$1,392.78	$699.24	$278.56
23485	T	Revision of collarbone	253	26.33	$1,392.78	$699.24	$278.56
23490	T	Reinforce clavicle	253	26.33	$1,392.78	$699.24	$278.56
23491	T	Reinforce shoulderbones	253	26.33	$1,392.78	$699.24	$278.56
23500	T	Treat clavicle fracture	207	1.70	$90.11	$31.64	$18.02
23505	T	Treat clavicle fracture	207	1.70	$90.11	$31.64	$18.02
23515	T	Repair clavicle fracture	216	20.13	$1,064.67	$520.93	$212.93
23520	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23525	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23530	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23532	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23540	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23545	T	Treat clavicle dislocation	207	1.70	$90.11	$31.64	$18.02
23550	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23552	T	Repair clavicle dislocation	216	20.13	$1,064.67	$520.93	$212.93
23570	T	Treat shoulderblade fracture	207	1.70	$90.11	$31.64	$18.02
23575	T	Treat shoulderblade fracture	207	1.70	$90.11	$31.64	$18.02
23585	T	Repair scapula fracture	216	20.13	$1,064.67	$520.93	$212.93
23600	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23605	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23615	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
23616	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
23620	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23625	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
23630	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
23650	T	Treat shoulder dislocation	207	1.70	$90.11	$31.64	$18.02
23655	T	Treat shoulder dislocation	210	10.46	$553.39	$283.40	$110.68
23660	T	Repair shoulder dislocation	216	20.13	$1,064.67	$520.93	$212.93
23665	T	Treat dislocation/fracture	209	1.94	$102.84	$37.29	$20.57
23670	T	Repair dislocation/fracture	216	20.13	$1,064.67	$520.93	$212.93
23675	T	Treat dislocation/fracture	209	1.94	$102.84	$37.29	$20.57
23680	T	Repair dislocation/fracture	216	20.13	$1,064.67	$520.93	$212.93
23700	T	Fixation of shoulder	210	10.46	$553.39	$283.40	$110.68
23800	T	Fusion of shoulder joint	253	26.33	$1,392.78	$699.24	$278.56
23802	T	Fusion of shoulder joint	253	26.33	$1,392.78	$699.24	$278.56
23900	C	Amputation of arm & girdle	.....	.....	.....	.....	.....
23920	C	Amputation at shoulder joint	.....	.....	.....	.....	.....
23921	T	Amputation follow-up surgery	183	11.17	$590.61	$286.57	$118.12
23929	T	Shoulder surgery procedure	207	1.70	$90.11	$31.64	$18.02
23930	T	Drainage of arm lesion	132	6.04	$319.30	$134.24	$63.86
23931	T	Drainage of arm bursa	132	6.04	$319.30	$134.24	$63.86
23935	T	Drain arm/elbow bone lesion	251	14.26	$754.18	$366.12	$150.84
24000	T	Exploratory elbow surgery	252	19.39	$1,025.49	$509.18	$205.10
24006	T	Release elbow joint	252	19.39	$1,025.49	$509.18	$205.10
24065	T	Biopsy arm/elbow soft tissue	161	3.50	$185.12	$75.48	$37.02
24066	T	Biopsy arm/elbow soft tissue	163	10.69	$565.14	$264.65	$113.03
24075	T	Remove arm/elbow lesion	162	5.67	$299.71	$125.43	$59.94

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
24076	T	Remove arm/elbow lesion	163	10.69	$565.14	$264.65	$113.03
24077	T	Remove tumor of arm/elbow	163	10.69	$565.14	$264.65	$113.03
24100	T	Biopsy elbow joint lining	251	14.26	$754.18	$366.12	$150.84
24101	T	Explore/treat elbow joint	252	19.39	$1,025.49	$509.18	$205.10
24102	T	Remove elbow joint lining	252	19.39	$1,025.49	$509.18	$205.10
24105	T	Removal of elbow bursa	251	14.26	$754.18	$366.12	$150.84
24110	T	Remove humerus lesion	251	14.26	$754.18	$366.12	$150.84
24115	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24116	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24120	T	Remove elbow lesion	251	14.26	$754.18	$366.12	$150.84
24125	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24126	T	Remove/graft bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24130	T	Removal of head of radius	252	19.39	$1,025.49	$509.18	$205.10
24134	T	Removal of arm bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24136	T	Remove radius bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24138	T	Remove elbow bone lesion	252	19.39	$1,025.49	$509.18	$205.10
24140	T	Partial removal of arm bone	252	19.39	$1,025.49	$509.18	$205.10
24145	T	Partial removal of radius	252	19.39	$1,025.49	$509.18	$205.10
24147	T	Partial removal of elbow	252	19.39	$1,025.49	$509.18	$205.10
24149	C	Radical resection of elbow	.....	.....	.....	.....	.....
24150	C	Extensive humerus surgery	.....	.....	.....	.....	.....
24151	C	Extensive humerus surgery	.....	.....	.....	.....	.....
24152	C	Extensive radius surgery	.....	.....	.....	.....	.....
24153	C	Extensive radius surgery	.....	.....	.....	.....	.....
24155	T	Removal of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24160	T	Remove elbow joint implant	252	19.39	$1,025.49	$509.18	$205.10
24164	T	Remove radius head implant	252	19.39	$1,025.49	$509.18	$205.10
24200	T	Removal of arm foreign body	161	3.50	$185.12	$75.48	$37.02
24201	T	Removal of arm foreign body	163	10.69	$565.14	$264.65	$113.03
24220	T	Injection for elbow x-ray	347	2.93	$154.75	$62.15	$30.95
24301	T	Muscle/tendon transfer	252	19.39	$1,025.49	$509.18	$205.10
24305	T	Arm tendon lengthening	252	19.39	$1,025.49	$509.18	$205.10
24310	T	Revision of arm tendon	251	14.26	$754.18	$366.12	$150.84
24320	T	Repair of arm tendon	253	26.33	$1,392.78	$699.24	$278.56
24330	T	Revision of arm muscles	253	26.33	$1,392.78	$699.24	$278.56
24331	T	Revision of arm muscles	253	26.33	$1,392.78	$699.24	$278.56
24340	T	Repair of biceps tendon	253	26.33	$1,392.78	$699.24	$278.56
24341	T	Repair tendon/muscle arm	253	26.33	$1,392.78	$699.24	$278.56
24342	T	Repair of ruptured tendon	253	26.33	$1,392.78	$699.24	$278.56
24350	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24351	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24352	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24354	T	Repair of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24356	T	Revision of tennis elbow	252	19.39	$1,025.49	$509.18	$205.10
24360	T	Reconstruct elbow joint	217	20.48	$1,083.27	$526.81	$216.65
24361	T	Reconstruct elbow joint	218	27.50	$1,454.49	$715.52	$290.90
24362	T	Reconstruct elbow joint	218	27.50	$1,454.49	$715.52	$290.90
24363	T	Replace elbow joint	218	27.50	$1,454.49	$715.52	$290.90
24365	T	Reconstruct head of radius	217	20.48	$1,083.27	$526.81	$216.65
24366	T	Reconstruct head of radius	218	27.50	$1,454.49	$715.52	$290.90
24400	T	Revision of humerus	252	19.39	$1,025.49	$509.18	$205.10
24410	T	Revision of humerus	252	19.39	$1,025.49	$509.18	$205.10
24420	T	Revision of humerus	253	26.33	$1,392.78	$699.24	$278.56
24430	T	Repair of humerus	253	26.33	$1,392.78	$699.24	$278.56
24435	T	Repair humerus with graft	253	26.33	$1,392.78	$699.24	$278.56
24470	T	Revision of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24495	T	Decompression of forearm	252	19.39	$1,025.49	$509.18	$205.10
24498	T	Reinforce humerus	253	26.33	$1,392.78	$699.24	$278.56
24500	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24505	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24515	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24516	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24530	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24535	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24538	T	Treat humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24545	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24546	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24560	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24565	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24566	T	Treat humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24575	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24576	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24577	T	Treat humerus fracture	209	1.94	$102.84	$37.29	$20.57
24579	T	Repair humerus fracture	216	20.13	$1,064.67	$520.93	$212.93
24582	T	Treat humerus fracture	216	20.13	$1,064.67	$520.93	$212.93

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
24586	T	Repair elbow fracture	216	20.13	$1,064.67	$520.93	$212.93
24587	T	Repair elbow fracture	216	20.13	$1,064.67	$520.93	$212.93
24600	T	Treat elbow dislocation	209	1.94	$102.84	$37.29	$20.57
24605	T	Treat elbow dislocation	210	10.46	$553.39	$283.40	$110.68
24615	T	Repair elbow dislocation	216	20.13	$1,064.67	$520.93	$212.93
24620	T	Treat elbow fracture	209	1.94	$102.84	$37.29	$20.57
24635	T	Repair elbow fracture	216	20.13	$1,064.67	$520.93	$212.93
24640	T	Treat elbow dislocation	209	1.94	$102.84	$37.29	$20.57
24650	T	Treat radius fracture	209	1.94	$102.84	$37.29	$20.57
24655	T	Treat radius fracture	209	1.94	$102.84	$37.29	$20.57
24665	T	Repair radius fracture	216	20.13	$1,064.67	$520.93	$212.93
24666	T	Repair radius fracture	216	20.13	$1,064.67	$520.93	$212.93
24670	T	Treatment of ulna fracture	209	1.94	$102.84	$37.29	$20.57
24675	T	Treatment of ulna fracture	209	1.94	$102.84	$37.29	$20.57
24685	T	Repair ulna fracture	216	20.13	$1,064.67	$520.93	$212.93
24800	T	Fusion of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24802	T	Fusion/graft of elbow joint	253	26.33	$1,392.78	$699.24	$278.56
24900	C	Amputation of upper arm	.....	.....	.....	.....	.....
24920	C	Amputation of upper arm	.....	.....	.....	.....	.....
24925	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
24930	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
24931	C	Amputate upper arm & implant	.....	.....	.....	.....	.....
24935	C	Revision of amputation	.....	.....	.....	.....	.....
24940	C	Revision of upper arm	.....	.....	.....	.....	.....
24999	T	Upper arm/elbow surgery	209	1.94	$102.84	$37.29	$20.57
25000	T	Incision of tendon sheath	251	14.26	$754.18	$366.12	$150.84
25020	T	Decompression of forearm	251	14.26	$754.18	$366.12	$150.84
25023	T	Decompression of forearm	252	19.39	$1,025.49	$509.18	$205.10
25028	T	Drainage of forearm lesion	251	14.26	$754.18	$366.12	$150.84
25031	T	Drainage of forearm bursa	251	14.26	$754.18	$366.12	$150.84
25035	T	Treat forearm bone lesion	251	14.26	$754.18	$366.12	$150.84
25040	T	Explore/treat wrist joint	252	19.39	$1,025.49	$509.18	$205.10
25065	T	Biopsy forearm soft tissues	161	3.50	$185.12	$75.48	$37.02
25066	T	Biopsy forearm soft tissues	163	10.69	$565.14	$264.65	$113.03
25075	T	Removal of forearm lesion	162	5.67	$299.71	$125.43	$59.94
25076	T	Removal of forearm lesion	163	10.69	$565.14	$264.65	$113.03
25077	T	Remove tumor, forearm/wrist	163	10.69	$565.14	$264.65	$113.03
25085	T	Incision of wrist capsule	251	14.26	$754.18	$366.12	$150.84
25100	T	Biopsy of wrist joint	251	14.26	$754.18	$366.12	$150.84
25101	T	Explore/treat wrist joint	252	19.39	$1,025.49	$509.18	$205.10
25105	T	Remove wrist joint lining	252	19.39	$1,025.49	$509.18	$205.10
25107	T	Remove wrist joint cartilage	252	19.39	$1,025.49	$509.18	$205.10
25110	T	Remove wrist tendon lesion	251	14.26	$754.18	$366.12	$150.84
25111	T	Remove wrist tendon lesion	261	10.54	$557.31	$261.48	$111.46
25112	T	Remove wrist tendon lesion	261	10.54	$557.31	$261.48	$111.46
25115	T	Remove wrist/forearm lesion	251	14.26	$754.18	$366.12	$150.84
25116	T	Remove wrist/forearm lesion	251	14.26	$754.18	$366.12	$150.84
25118	T	Excise wrist tendon sheath	252	19.39	$1,025.49	$509.18	$205.10
25119	T	Partial removal of ulna	252	19.39	$1,025.49	$509.18	$205.10
25120	T	Removal of forearm lesion	252	19.39	$1,025.49	$509.18	$205.10
25125	T	Remove/graft forearm lesion	252	19.39	$1,025.49	$509.18	$205.10
25126	T	Remove/graft forearm lesion	252	19.39	$1,025.49	$509.18	$205.10
25130	T	Removal of wrist lesion	252	19.39	$1,025.49	$509.18	$205.10
25135	T	Remove & graft wrist lesion	252	19.39	$1,025.49	$509.18	$205.10
25136	T	Remove & graft wrist lesion	252	19.39	$1,025.49	$509.18	$205.10
25145	T	Remove forearm bone lesion	252	19.39	$1,025.49	$509.18	$205.10
25150	T	Partial removal of ulna	252	19.39	$1,025.49	$509.18	$205.10
25151	T	Partial removal of radius	252	19.39	$1,025.49	$509.18	$205.10
25170	C	Extensive forearm surgery	.....	.....	.....	.....	.....
25210	T	Removal of wrist bone	262	18.35	$970.64	$480.93	$194.13
25215	T	Removal of wrist bones	262	18.35	$970.64	$480.93	$194.13
25230	T	Partial removal of radius	252	19.39	$1,025.49	$509.18	$205.10
25240	T	Partial removal of ulna	252	19.39	$1,025.49	$509.18	$205.10
25246	T	Injection for wrist x-ray	347	2.93	$154.75	$62.15	$30.95
25248	T	Remove forearm foreign body	251	14.26	$754.18	$366.12	$150.84
25250	T	Removal of wrist prosthesis	252	19.39	$1,025.49	$509.18	$205.10
25251	T	Removal of wrist prosthesis	252	19.39	$1,025.49	$509.18	$205.10
25260	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25263	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25265	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25270	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25272	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25274	T	Repair forearm tendon/muscle	252	19.39	$1,025.49	$509.18	$205.10
25280	T	Revise wrist/forearm tendon	252	19.39	$1,025.49	$509.18	$205.10
25290	T	Incise wrist/forearm tendon	252	19.39	$1,025.49	$509.18	$205.10

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
25295	T	Release wrist/forearm tendon	251	14.26	$754.18	$366.12	$150.84
25300	T	Fusion of tendons at wrist	252	19.39	$1,025.49	$509.18	$205.10
25301	T	Fusion of tendons at wrist	252	19.39	$1,025.49	$509.18	$205.10
25310	T	Transplant forearm tendon	253	26.33	$1,392.78	$699.24	$278.56
25312	T	Transplant forearm tendon	253	26.33	$1,392.78	$699.24	$278.56
25315	T	Revise palsy hand tendon(s)	253	26.33	$1,392.78	$699.24	$278.56
25316	T	Revise palsy hand tendon(s)	253	26.33	$1,392.78	$699.24	$278.56
25320	T	Repair/revise wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25332	T	Revise wrist joint	217	20.48	$1,083.27	$526.81	$216.65
25335	T	Realignment of hand	253	26.33	$1,392.78	$699.24	$278.56
25337	T	Reconstruct ulna/radioulnar	253	26.33	$1,392.78	$699.24	$278.56
25350	T	Revision of radius	253	26.33	$1,392.78	$699.24	$278.56
25355	T	Revision of radius	253	26.33	$1,392.78	$699.24	$278.56
25360	T	Revision of ulna	252	19.39	$1,025.49	$509.18	$205.10
25365	T	Revise radius & ulna	252	19.39	$1,025.49	$509.18	$205.10
25370	T	Revise radius or ulna	253	26.33	$1,392.78	$699.24	$278.56
25375	T	Revise radius & ulna	253	26.33	$1,392.78	$699.24	$278.56
25390	C	Shorten radius/ulna					
25391	C	Lengthen radius/ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
25400	T	Repair radius or ulna	252	19.39	$1,025.49	$509.18	$205.10
25405	C	Repair/graft radius or ulna					
25415	T	Repair radius & ulna	252	19.39	$1,025.49	$509.18	$205.10
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	253	26.33	$1,392.78	$699.24	$278.56
25426	T	Repair/graft radius & ulna	253	26.33	$1,392.78	$699.24	$278.56
25440	T	Repair/graft wrist bone	253	26.33	$1,392.78	$699.24	$278.56
25441	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25442	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25443	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25444	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25445	T	Reconstruct wrist joint	218	27.50	$1,454.49	$715.52	$290.90
25446	T	Wrist replacement	218	27.50	$1,454.49	$715.52	$290.90
25447	T	Repair wrist joint(s)	217	20.48	$1,083.27	$526.81	$216.65
25449	T	Remove wrist joint implant	217	20.48	$1,083.27	$526.81	$216.65
25450	T	Revision of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25455	T	Revision of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25490	T	Reinforce radius	253	26.33	$1,392.78	$699.24	$278.56
25491	T	Reinforce ulna	253	26.33	$1,392.78	$699.24	$278.56
25492	T	Reinforce radius and ulna	253	26.33	$1,392.78	$699.24	$278.56
25500	T	Treat fracture of radius	209	1.94	$102.84	$37.29	$20.57
25505	T	Treat fracture of radius	209	1.94	$102.84	$37.29	$20.57
25515	T	Repair fracture of radius	216	20.13	$1,064.67	$520.93	$212.93
25520	T	Repair fracture of radius	209	1.94	$102.84	$37.29	$20.57
25525	T	Repair fracture of radius	216	20.13	$1,064.67	$520.93	$212.93
25526	T	Repair fracture of radius	216	20.13	$1,064.67	$520.93	$212.93
25530	T	Treat fracture of ulna	209	1.94	$102.84	$37.29	$20.57
25535	T	Treat fracture of ulna	209	1.94	$102.84	$37.29	$20.57
25545	T	Repair fracture of ulna	216	20.13	$1,064.67	$520.93	$212.93
25560	T	Treat fracture radius & ulna	209	1.94	$102.84	$37.29	$20.57
25565	T	Treat fracture radius & ulna	209	1.94	$102.84	$37.29	$20.57
25574	T	Treat fracture radius & ulna	216	20.13	$1,064.67	$520.93	$212.93
25575	T	Repair fracture radius/ulna	216	20.13	$1,064.67	$520.93	$212.93
25600	T	Treat fracture radius/ulna	209	1.94	$102.84	$37.29	$20.57
25605	T	Treat fracture radius/ulna	209	1.94	$102.84	$37.29	$20.57
25611	T	Repair fracture radius/ulna	216	20.13	$1,064.67	$520.93	$212.93
25620	T	Repair fracture radius/ulna	216	20.13	$1,064.67	$520.93	$212.93
25622	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25624	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25628	T	Repair wrist bone fracture	216	20.13	$1,064.67	$520.93	$212.93
25630	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25635	T	Treat wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25645	T	Repair wrist bone fracture	216	20.13	$1,064.67	$520.93	$212.93
25650	T	Repair wrist bone fracture	209	1.94	$102.84	$37.29	$20.57
25660	T	Treat wrist dislocation	209	1.94	$102.84	$37.29	$20.57
25670	T	Repair wrist dislocation	216	20.13	$1,064.67	$520.93	$212.93
25675	T	Treat wrist dislocation	209	1.94	$102.84	$37.29	$20.57
25676	T	Repair wrist dislocation	216	20.13	$1,064.67	$520.93	$212.93
25680	T	Treat wrist fracture	209	1.94	$102.84	$37.29	$20.57
25685	T	Repair wrist fracture	216	20.13	$1,064.67	$520.93	$212.93
25690	T	Treat wrist dislocation	209	1.94	102.84	$37.29	$20.57
25695	T	Repair wrist dislocation	216	20.13	$1,064.67	$520.93	$212.93
25800	T	Fusion of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25805	T	Fusion/graft of wrist joint	253	26.33	$1,392.78	$699.24	$278.56

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
25810	T	Fusion/graft of wrist joint	253	26.33	$1,392.78	$699.24	$278.56
25820	T	Fusion of hand bones	261	10.54	$557.31	$261.48	$111.46
25825	T	Fusion hand bones with graft	262	18.35	$970.64	$480.93	$194.13
25830	T	Fusion radioulnar jnt/ulna	253	26.33	$1,392.78	$699.24	$278.56
25900	C	Amputation of forearm	.....	.....	.....	.....	.....
25905	C	Amputation of forearm	.....	.....	.....	.....	.....
25907	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
25909	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25915	C	Amputation of forearm	.....	.....	.....	.....	.....
25920	C	Amputate hand at wrist	.....	.....	.....	.....	.....
25922	T	Amputate hand at wrist	251	14.26	$754.18	$366.12	$150.84
25924	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25927	C	Amputation of hand	.....	.....	.....	.....	.....
25929	T	Amputation follow-up surgery	183	11.17	$590.61	$286.57	$118.12
25931	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
25999	T	Forearm or wrist surgery	209	1.94	$102.84	$37.29	$20.57
26010	T	Drainage of finger abscess	131	1.94	$102.84	$36.61	$20.57
26011	T	Drainage of finger abscess	131	1.94	$102.84	$36.61	$20.57
26020	T	Drain hand tendon sheath	261	10.54	$557.31	$261.48	$111.46
26025	T	Drainage of palm bursa	261	10.54	$557.31	$261.48	$111.46
26030	T	Drainage of palm bursa(s)	261	10.54	$557.31	$261.48	$111.46
26034	T	Treat hand bone lesion	261	10.54	$557.31	$261.48	$111.46
26035	T	Decompress fingers/hand	261	10.54	$557.31	$261.48	$111.46
26037	T	Decompress fingers/hand	261	10.54	$557.31	$261.48	$111.46
26040	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26045	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26055	T	Incise finger tendon sheath	261	10.54	$557.31	$261.48	$111.46
26060	T	Incision of finger tendon	261	10.54	$557.31	$261.48	$111.46
26070	T	Explore/treat hand joint	261	10.54	$557.31	$261.48	$111.46
26075	T	Explore/treat finger joint	261	10.54	$557.31	$261.48	$111.46
26080	T	Explore/treat finger joint	261	10.54	$557.31	$261.48	$111.46
26100	T	Biopsy hand joint lining	261	10.54	$557.31	$261.48	$111.46
26105	T	Biopsy finger joint lining	261	10.54	$557.31	$261.48	$111.46
26110	T	Biopsy finger joint lining	261	10.54	$557.31	$261.48	$111.46
26115	T	Removal of hand lesion	163	10.69	$565.14	$264.65	$113.03
26116	T	Removal of hand lesion	163	10.69	$565.14	$264.65	$113.03
26117	T	Remove tumor, hand/finger	163	10.69	$565.14	$264.65	$113.03
26121	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26123	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26125	T	Release palm contracture	262	18.35	$970.64	$480.93	$194.13
26130	T	Remove wrist joint lining	261	10.54	$557.31	$261.48	$111.46
26135	T	Revise finger joint, each	262	18.35	$970.64	$480.93	$194.13
26140	T	Revise finger joint, each	261	10.54	$557.31	$261.48	$111.46
26145	T	Tendon excision, palm/finger	261	10.54	$557.31	$261.48	$111.46
26160	T	Remove tendon sheath lesion	261	10.54	$557.31	$261.48	$111.46
26170	T	Removal of palm tendon, each	261	10.54	$557.31	$261.48	$111.46
26180	T	Removal of finger tendon	261	10.54	$557.31	$261.48	$111.46
26185	T	Remove finger bone	261	10.54	$557.31	$261.48	$111.46
26200	T	Remove hand bone lesion	261	10.54	$557.31	$261.48	$111.46
26205	T	Remove/graft bone lesion	262	18.35	$970.64	$480.93	$194.13
26210	T	Removal of finger lesion	261	10.54	$557.31	$261.48	$111.46
26215	T	Remove/graft finger lesion	261	10.54	$557.31	$261.48	$111.46
26230	T	Partial removal of hand bone	261	10.54	$557.31	$261.48	$111.46
26235	T	Partial removal, finger bone	261	10.54	$557.31	$261.48	$111.46
26236	T	Partial removal, finger bone	261	10.54	$557.31	$261.48	$111.46
26250	T	Extensive hand surgery	261	10.54	$557.31	$261.48	$111.46
26255	T	Extensive hand surgery	262	18.35	$970.64	$480.93	$194.13
26260	T	Extensive finger surgery	261	10.54	$557.31	$261.48	$111.46
26261	T	Extensive finger surgery	261	10.54	$557.31	$261.48	$111.46
26262	T	Partial removal of finger	261	10.54	$557.31	$261.48	$111.46
26320	T	Removal of implant from hand	163	10.69	$565.14	$264.65	$113.03
26350	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26352	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26356	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26357	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26358	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26370	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26372	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26373	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26390	T	Revise hand/finger tendon	262	18.35	$970.64	$480.93	$194.13
26392	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26410	T	Repair hand tendon	261	10.54	$557.31	$261.48	$111.46
26412	T	Repair/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26415	T	Excision, hand/finger tendon	262	18.35	$970.64	$480.93	$194.13
26416	T	Graft hand or finger tendon	262	18.35	$970.64	$480.93	$194.13

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
26418	T	Repair finger tendon	261	10.54	$557.31	$261.48	$111.46
26420	T	Repair/graft finger tendon	262	18.35	$970.64	$480.93	$194.13
26426	T	Repair finger/hand tendon	262	18.35	$970.64	$480.93	$194.13
26428	T	Repair/graft finger tendon	262	18.35	$970.64	$480.93	$194.13
26432	T	Repair finger tendon	261	10.54	$557.31	$261.48	$111.46
26433	T	Repair finger tendon	261	10.54	$557.31	$261.48	$111.46
26434	T	Repair/graft finger tendon	262	18.35	$970.64	$480.93	$194.13
26437	T	Realignment of tendons	261	10.54	$557.31	$261.48	$111.46
26440	T	Release palm/finger tendon	261	10.54	$557.31	$261.48	$111.46
26442	T	Release palm & finger tendon	262	18.35	$970.64	$480.93	$194.13
26445	T	Release hand/finger tendon	261	10.54	$557.31	$261.48	$111.46
26449	T	Release forearm/hand tendon	262	18.35	$970.64	$480.93	$194.13
26450	T	Incision of palm tendon	261	10.54	$557.31	$261.48	$111.46
26455	T	Incision of finger tendon	261	10.54	$557.31	$261.48	$111.46
26460	T	Incise hand/finger tendon	261	10.54	$557.31	$261.48	$111.46
26471	T	Fusion of finger tendons	261	10.54	$557.31	$261.48	$111.46
26474	T	Fusion of finger tendons	261	10.54	$557.31	$261.48	$111.46
26476	T	Tendon lengthening	261	10.54	$557.31	$261.48	$111.46
26477	T	Tendon shortening	261	10.54	$557.31	$261.48	$111.46
26478	T	Lengthening of hand tendon	261	10.54	$557.31	$261.48	$111.46
26479	T	Shortening of hand tendon	261	10.54	$557.31	$261.48	$111.46
26480	T	Transplant hand tendon	262	18.35	$970.64	$480.93	$194.13
26483	T	Transplant/graft hand tendon	262	18.35	$970.64	$480.93	$194.13
26485	T	Transplant palm tendon	262	18.35	$970.64	$480.93	$194.13
26489	T	Transplant/graft palm tendon	262	18.35	$970.64	$480.93	$194.13
26490	T	Revise thumb tendon	262	18.35	$970.64	$480.93	$194.13
26492	T	Tendon transfer with graft	262	18.35	$970.64	$480.93	$194.13
26494	T	Hand tendon/muscle transfer	262	18.35	$970.64	$480.93	$194.13
26496	T	Revise thumb tendon	262	18.35	$970.64	$480.93	$194.13
26497	T	Finger tendon transfer	262	18.35	$970.64	$480.93	$194.13
26498	T	Finger tendon transfer	262	18.35	$970.64	$480.93	$194.13
26499	T	Revision of finger	262	18.35	$970.64	$480.93	$194.13
26500	T	Hand tendon reconstruction	261	10.54	$557.31	$261.48	$111.46
26502	T	Hand tendon reconstruction	262	18.35	$970.64	$480.93	$194.13
26504	T	Hand tendon reconstruction	262	18.35	$970.64	$480.93	$194.13
26508	T	Release thumb contracture	261	10.54	$557.31	$261.48	$111.46
26510	T	Thumb tendon transfer	262	18.35	$970.64	$480.93	$194.13
26516	T	Fusion of knuckle joint	262	18.35	$970.64	$480.93	$194.13
26517	T	Fusion of knuckle joints	262	18.35	$970.64	$480.93	$194.13
26518	T	Fusion of knuckle joints	262	18.35	$970.64	$480.93	$194.13
26520	T	Release knuckle contracture	261	10.54	$557.31	$261.48	$111.46
26525	T	Release finger contracture	261	10.54	$557.31	$261.48	$111.46
26530	T	Revise knuckle joint	217	20.48	$1,083.27	$526.81	$216.65
26531	T	Revise knuckle with implant	218	27.50	$1,454.49	$715.52	$290.90
26535	T	Revise finger joint	217	20.48	$1,083.27	$526.81	$216.65
26536	T	Revise/implant finger joint	218	27.50	$1,454.49	$715.52	$290.90
26540	T	Repair hand joint	261	10.54	$557.31	$261.48	$111.46
26541	T	Repair hand joint with graft	262	18.35	$970.64	$480.93	$194.13
26542	T	Repair hand joint with graft	261	10.54	$557.31	$261.48	$111.46
26545	T	Reconstruct finger joint	262	18.35	$970.64	$480.93	$194.13
26546	T	Repair non-union hand	262	18.35	$970.64	$480.93	$194.13
26548	T	Reconstruct finger joint	262	18.35	$970.64	$480.93	$194.13
26550	T	Construct thumb replacement	262	18.35	$970.64	$480.93	$194.13
26551	C	Great toe-hand transfer	.....	.....	.....	.....	.....
26553	C	Single toe-hand transfer	.....	.....	.....	.....	.....
26554	C	Double toe-hand transfer	.....	.....	.....	.....	.....
26555	T	Positional change of finger	262	18.35	$970.64	$480.93	$194.13
26556	C	Toe joint transfer	.....	.....	.....	.....	.....
26560	T	Repair of web finger	261	10.54	$557.31	$261.48	$111.46
26561	T	Repair of web finger	262	18.35	$970.64	$480.93	$194.13
26562	T	Repair of web finger	262	18.35	$970.64	$480.93	$194.13
26565	T	Correct metacarpal flaw	262	18.35	$970.64	$480.93	$194.13
26567	T	Correct finger deformity	262	18.35	$970.64	$480.93	$194.13
26568	T	Lengthen metacarpal/finger	262	18.35	$970.64	$480.93	$194.13
26580	T	Repair hand deformity	262	18.35	$970.64	$480.93	$194.13
26585	T	Repair finger deformity	262	18.35	$970.64	$480.93	$194.13
26587	T	Reconstruct extra finger	261	10.54	$557.31	$261.48	$111.46
26590	T	Repair finger deformity	262	18.35	$970.64	$480.93	$194.13
26591	T	Repair muscles of hand	262	18.35	$970.64	$480.93	$194.13
26593	T	Release muscles of hand	261	10.54	$557.31	$261.48	$111.46
26596	T	Excision constricting tissue	262	18.35	$970.64	$480.93	$194.13
26597	T	Release of scar contracture	262	18.35	$970.64	$480.93	$194.13
26600	T	Treat metacarpal fracture	209	1.94	$102.84	$37.29	$20.57
26605	T	Treat metacarpal fracture	209	1.94	$102.84	$37.29	$20.57
26607	T	Treat metacarpal fracture	209	1.94	$102.84	$37.29	$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
26608	T	Treat metacarpal fracture	216	20.13	$1,064.67	$520.93	$212.93
26615	T	Repair metacarpal fracture	216	20.13	$1,064.67	$520.93	$212.93
26641	T	Treat thumb dislocation	209	1.94	$102.84	$37.29	$20.57
26645	T	Treat thumb fracture	209	1.94	$102.84	$37.29	$20.57
26650	T	Repair thumb fracture	216	20.13	$1,064.67	$520.93	$212.93
26665	T	Repair thumb fracture	216	20.13	$1,064.67	$520.93	$212.93
26670	T	Treat hand dislocation	209	1.94	$102.84	$37.29	$20.57
26675	T	Treat hand dislocation	210	10.46	$553.39	$283.4	$110.68
26676	T	Pin hand dislocation	216	20.13	$1,064.67	$520.93	$212.93
26685	T	Repair hand dislocation	216	20.13	$1,064.67	$520.93	$212.93
26686	T	Repair hand dislocation	216	20.13	$1,064.67	$520.93	$212.93
26700	T	Treat knuckle dislocation	207	1.70	$90.11	$31.64	$18.02
26705	T	Treat knuckle dislocation	210	10.46	$553.39	$283.4	$110.68
26706	T	Pin knuckle dislocation	209	1.94	$102.84	$37.29	$20.57
26715	T	Repair knuckle dislocation	216	20.13	$1,064.67	$520.93	$212.93
26720	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26725	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26727	T	Treat finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26735	T	Repair finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26740	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26742	T	Treat finger fracture, each	209	1.94	$102.84	$37.29	$20.57
26746	T	Repair finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26750	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26755	T	Treat finger fracture, each	207	1.70	$90.11	$31.64	$18.02
26756	T	Pin finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26765	T	Repair finger fracture, each	216	20.13	$1,064.67	$520.93	$212.93
26770	T	Treat finger dislocation	207	1.70	$90.11	$31.64	$18.02
26775	T	Treat finger dislocation	210	10.46	$553.39	$283.4	$110.68
26776	T	Pin finger dislocation	216	20.13	$1,064.67	$520.93	$212.93
26785	T	Repair finger dislocation	216	20.13	$1,064.67	$520.93	$212.93
26820	T	Thumb fusion with graft	262	18.35	$970.64	$480.93	$194.13
26841	T	Fusion of thumb	262	18.35	$970.64	$480.93	$194.13
26842	T	Thumb fusion with graft	262	18.35	$970.64	$480.93	$194.13
26843	T	Fusion of hand joint	262	18.35	$970.64	$480.93	$194.13
26844	T	Fusion/graft of hand joint	262	18.35	$970.64	$480.93	$194.13
26850	T	Fusion of knuckle	262	18.35	$970.64	$480.93	$194.13
26852	T	Fusion of knuckle with graft	262	18.35	$970.64	$480.93	$194.13
26860	T	Fusion of finger joint	262	18.35	$970.64	$480.93	$194.13
26861	T	Fusion of finger joint, added	262	18.35	$970.64	$480.93	$194.13
26862	T	Fusion/graft of finger joint	262	18.35	$970.64	$480.93	$194.13
26863	T	Fuse/graft added joint	262	18.35	$970.64	$480.93	$194.13
26910	T	Amputate metacarpal bone	262	18.35	$970.64	$480.93	$194.13
26951	T	Amputation of finger/thumb	261	10.54	$557.31	$261.48	$111.46
26952	T	Amputation of finger/thumb	261	10.54	$557.31	$261.48	$111.46
26989	T	Hand/finger surgery	207	1.70	$90.11	$31.64	$18.02
26990	T	Drainage of pelvis lesion	251	14.26	$754.18	$366.12	$150.84
26991	T	Drainage of pelvis bursa	251	14.26	$754.18	$366.12	$150.84
26992	C	Drainage of bone lesion	.....	.....	.....	.....	.....
27000	T	Incision of hip tendon	251	14.26	$754.18	$366.12	$150.84
27001	T	Incision of hip tendon	252	19.39	$1,025.49	$509.18	$205.10
27003	T	Incision of hip tendon	252	19.39	$1,025.49	$509.18	$205.10
27005	C	Incision of hip tendon	.....	.....	.....	.....	.....
27006	C	Incision of hip tendons	.....	.....	.....	.....	.....
27025	C	Incision of hip/thigh fascia	.....	.....	.....	.....	.....
27030	C	Drainage of hip joint	.....	.....	.....	.....	.....
27033	T	Exploration of hip joint	253	26.33	$1,392.78	$699.24	$278.56
27035	C	Denervation of hip joint	.....	.....	.....	.....	.....
27036	C	Excision of hip joint/muscle	.....	.....	.....	.....	.....
27040	T	Biopsy of soft tissues	162	5.67	$299.71	$125.43	$59.94
27041	T	Biopsy of soft tissues	163	10.69	$565.14	$264.65	$113.03
27047	T	Remove hip/pelvis lesion	163	10.69	$565.14	$264.65	$113.03
27048	T	Remove hip/pelvis lesion	163	10.69	$565.14	$264.65	$113.03
27049	T	Remove tumor, hip/pelvis	163	10.69	$565.14	$264.65	$113.03
27050	T	Biopsy of sacroiliac joint	251	14.26	$754.18	$366.12	$150.84
27052	T	Biopsy of hip joint	251	14.26	$754.18	$366.12	$150.84
27054	C	Removal of hip joint lining	.....	.....	.....	.....	.....
27060	T	Removal of ischial bursa	251	14.26	$754.18	$366.12	$150.84
27062	T	Remove femur lesion/bursa	251	14.26	$754.18	$366.12	$150.84
27065	T	Removal of hip bone lesion	251	14.26	$754.18	$366.12	$150.84
27066	T	Removal of hip bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27067	T	Remove/graft hip bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27070	C	Partial removal of hip bone	.....	.....	.....	.....	.....
27071	C	Partial removal of hip bone	.....	.....	.....	.....	.....
27075	C	Extensive hip surgery	.....	.....	.....	.....	.....
27076	C	Extensive hip surgery	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27077	C	Extensive hip surgery	.....	.....	.....	.....	.....
27078	C	Extensive hip surgery	.....	.....	.....	.....	.....
27079	C	Extensive hip surgery	.....	.....	.....	.....	.....
27080	T	Removal of tail bone	252	19.39	$1,025.49	$509.18	$205.10
27086	T	Remove hip foreign body	251	14.26	$754.18	$366.12	$150.84
27087	T	Remove hip foreign body	251	14.26	$754.18	$366.12	$150.84
27090	C	Removal of hip prosthesis	.....	.....	.....	.....	.....
27091	C	Removal of hip prosthesis	.....	.....	.....	.....	.....
27093	T	Injection for hip x-ray	347	2.93	$154.75	$62.15	$30.95
27095	T	Injection for hip x-ray	347	2.93	$154.75	$62.15	$30.95
27097	T	Revision of hip tendon	252	19.39	$1,025.49	$509.18	$205.10
27098	T	Transfer tendon to pelvis	252	19.39	$1,025.49	$509.18	$205.10
27100	T	Transfer of abdominal muscle	253	26.33	$1,392.78	$699.24	$278.56
27105	T	Transfer of spinal muscle	253	26.33	$1,392.78	$699.24	$278.56
27110	T	Transfer of iliopsoas muscle	253	26.33	$1,392.78	$699.24	$278.56
27111	T	Transfer of iliopsoas muscle	253	26.33	$1,392.78	$699.24	$278.56
27120	C	Reconstruction of hip socket	.....	.....	.....	.....	.....
27122	C	Reconstruction of hip socket	.....	.....	.....	.....	.....
27125	C	Partial hip replacement	.....	.....	.....	.....	.....
27130	C	Total hip replacement	.....	.....	.....	.....	.....
27132	C	Total hip replacement	.....	.....	.....	.....	.....
27134	C	Revise hip joint replacement	.....	.....	.....	.....	.....
27137	C	Revise hip joint replacement	.....	.....	.....	.....	.....
27138	C	Revise hip joint replacement	.....	.....	.....	.....	.....
27140	C	Transplant of femur ridge	.....	.....	.....	.....	.....
27146	C	Incision of hip bone	.....	.....	.....	.....	.....
27147	C	Revision of hip bone	.....	.....	.....	.....	.....
27151	C	Incision of hip bones	.....	.....	.....	.....	.....
27156	C	Revision of hip bones	.....	.....	.....	.....	.....
27158	C	Revision of pelvis	.....	.....	.....	.....	.....
27161	C	Incision of neck of femur	.....	.....	.....	.....	.....
27165	C	Incision/fixation of femur	.....	.....	.....	.....	.....
27170	C	Repair/graft femur head/neck	.....	.....	.....	.....	.....
27175	C	Treat slipped epiphysis	.....	.....	.....	.....	.....
27176	C	Treat slipped epiphysis	.....	.....	.....	.....	.....
27177	C	Repair slipped epiphysis	.....	.....	.....	.....	.....
27178	C	Repair slipped epiphysis	.....	.....	.....	.....	.....
27179	C	Revise head/neck of femur	.....	.....	.....	.....	.....
27181	C	Repair slipped epiphysis	.....	.....	.....	.....	.....
27185	C	Revision of femur epiphysis	.....	.....	.....	.....	.....
27187	C	Reinforce hip bones	.....	.....	.....	.....	.....
27193	T	Treat pelvic ring fracture	209	1.94	$102.84	$37.29	$20.57
27194	T	Treat pelvic ring fracture	210	10.46	$553.39	$283.4	$110.68
27200	T	Treat tail bone fracture	207	1.70	$90.11	$31.64	$18.02
27202	T	Repair tail bone fracture	216	20.13	$1,064.67	$520.93	$212.93
27215	C	Pelvic fracture(s) treatment	.....	.....	.....	.....	.....
27216	C	Treat pelvic ring fracture	.....	.....	.....	.....	.....
27217	C	Treat pelvic ring fracture	.....	.....	.....	.....	.....
27218	C	Treat pelvic ring fracture	.....	.....	.....	.....	.....
27220	T	Treat hip socket fracture	209	1.94	$102.84	$37.29	$20.57
27222	C	Treat hip socket fracture	.....	.....	.....	.....	.....
27226	C	Treat hip wall fracture	.....	.....	.....	.....	.....
27227	C	Treat hip fracture(s)	.....	.....	.....	.....	.....
27228	C	Treat hip fracture(s)	.....	.....	.....	.....	.....
27230	T	Treat fracture of thigh	209	1.94	$102.84	$37.29	$20.57
27232	C	Treat fracture of thigh	.....	.....	.....	.....	.....
27235	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27236	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27238	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27240	C	Treatment of thigh fracture	.....	.....	.....	.....	.....
27244	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27245	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27246	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27248	C	Repair of thigh fracture	.....	.....	.....	.....	.....
27250	T	Treat hip dislocation	209	1.94	$102.84	$37.29	$20.57
27252	T	Treat hip dislocation	210	10.46	$553.39	$283.4	$110.68
27253	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27254	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27256	T	Treatment of hip dislocation	209	1.94	$102.84	$37.29	$20.57
27257	T	Treatment of hip dislocation	210	10.46	$553.39	$283.4	$110.68
27258	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27259	C	Repair of hip dislocation	.....	.....	.....	.....	.....
27265	T	Treatment of hip dislocation	209	1.94	$102.84	$37.29	$20.57
27266	T	Treatment of hip dislocation	217	20.48	$1,083.27	$526.81	$216.65
27275	T	Manipulation of hip joint	210	10.46	$553.39	$283.4	$110.68

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27280	C	Fusion of sacroiliac joint	.....	.....	.....	.....	.....
27282	C	Fusion of pubic bones	.....	.....	.....	.....	.....
27284	C	Fusion of hip joint	.....	.....	.....	.....	.....
27286	C	Fusion of hip joint	.....	.....	.....	.....	.....
27290	C	Amputation of leg at hip	.....	.....	.....	.....	.....
27295	C	Amputation of leg at hip	.....	.....	.....	.....	.....
27299	T	Pelvis/hip joint surgery	207	1.70	$90.11	$31.64	$18.02
27301	T	Drain thigh/knee lesion	132	6.04	$319.3	$134.24	$63.86
27303	C	Drainage of bone lesion	.....	.....	.....	.....	.....
27305	T	Incise thigh tendon & fascia	251	14.26	$754.18	$366.12	$150.84
27306	T	Incision of thigh tendon	251	14.26	$754.18	$366.12	$150.84
27307	T	Incision of thigh tendons	251	14.26	$754.18	$366.12	$150.84
27310	T	Exploration of knee joint	252	19.39	$1,025.49	$509.18	$205.10
27315	T	Partial removal, thigh nerve	631	12.98	$686.6	$333.8	$137.32
27320	T	Partial removal, thigh nerve	631	12.98	$686.6	$333.8	$137.32
27323	T	Biopsy thigh soft tissues	162	5.67	$299.71	$125.43	$59.94
27324	T	Biopsy thigh soft tissues	163	10.69	$565.14	$264.65	$113.03
27327	T	Removal of thigh lesion	163	10.69	$565.14	$264.65	$113.03
27328	T	Removal of thigh lesion	163	10.69	$565.14	$264.65	$113.03
27329	T	Remove tumor, thigh/knee	163	10.69	$565.14	$264.65	$113.03
27330	T	Biopsy knee joint lining	252	19.39	$1,025.49	$509.18	$205.10
27331	T	Explore/treat knee joint	252	19.39	$1,025.49	$509.18	$205.10
27332	T	Removal of knee cartilage	252	19.39	$1,025.49	$509.18	$205.10
27333	T	Removal of knee cartilage	252	19.39	$1,025.49	$509.18	$205.10
27334	T	Remove knee joint lining	252	19.39	$1,025.49	$509.18	$205.10
27335	T	Remove knee joint lining	252	19.39	$1,025.49	$509.18	$205.10
27340	T	Removal of kneecap bursa	251	14.26	$754.18	$366.12	$150.84
27345	T	Removal of knee cyst	251	14.26	$754.18	$366.12	$150.84
27350	T	Removal of kneecap	252	19.39	$1,025.49	$509.18	$205.10
27355	T	Remove femur lesion	252	19.39	$1,025.49	$509.18	$205.10
27356	T	Remove femur lesion/graft	252	19.39	$1,025.49	$509.18	$205.10
27357	T	Remove femur lesion/graft	252	19.39	$1,025.49	$509.18	$205.10
27358	T	Remove femur lesion/fixation	252	19.39	$1,025.49	$509.18	$205.10
27360	T	Partial removal leg bone(s)	252	19.39	$1,025.49	$509.18	$205.10
27365	C	Extensive leg surgery	.....	.....	.....	.....	.....
27370	T	Injection for knee x-ray	347	2.93	$154.75	$62.15	$30.95
27372	T	Removal of foreign body	163	10.69	$565.14	$264.65	$113.03
27380	T	Repair of kneecap tendon	251	14.26	$754.18	$366.12	$150.84
27381	T	Repair/graft kneecap tendon	251	14.26	$754.18	$366.12	$150.84
27385	T	Repair of thigh muscle	251	14.26	$754.18	$366.12	$150.84
27386	T	Repair/graft of thigh muscle	251	14.26	$754.18	$366.12	$150.84
27390	T	Incision of thigh tendon	251	14.26	$754.18	$366.12	$150.84
27391	T	Incision of thigh tendons	251	14.26	$754.18	$366.12	$150.84
27392	T	Incision of thigh tendons	251	14.26	$754.18	$366.12	$150.84
27393	T	Lengthening of thigh tendon	252	19.39	$1,025.49	$509.18	$205.10
27394	T	Lengthening of thigh tendons	252	19.39	$1,025.49	$509.18	$205.10
27395	T	Lengthening of thigh tendons	253	26.33	$1,392.78	$699.24	$278.56
27396	T	Transplant of thigh tendon	252	19.39	$1,025.49	$509.18	$205.10
27397	T	Transplants of thigh tendons	253	26.33	$1,392.78	$699.24	$278.56
27400	T	Revise thigh muscles/tendons	253	26.33	$1,392.78	$699.24	$278.56
27403	T	Repair of knee cartilage	252	19.39	$1,025.49	$509.18	$205.10
27405	T	Repair of knee ligament	253	26.33	$1,392.78	$699.24	$278.56
27407	T	Repair of knee ligament	253	26.33	$1,392.78	$699.24	$278.56
27409	T	Repair of knee ligaments	253	26.33	$1,392.78	$699.24	$278.56
27418	T	Repair degenerated kneecap	253	26.33	$1,392.78	$699.24	$278.56
27420	T	Revision of unstable kneecap	253	26.33	$1,392.78	$699.24	$278.56
27422	T	Revision of unstable kneecap	253	26.33	$1,392.78	$699.24	$278.56
27424	T	Revision/removal of kneecap	253	26.33	$1,392.78	$699.24	$278.56
27425	T	Lateral retinacular release	252	19.39	$1,025.49	$509.18	$205.10
27427	T	Reconstruction, knee	254	34.37	$1,817.86	$937.22	$363.57
27428	T	Reconstruction, knee	254	34.37	$1,817.86	$937.22	$363.57
27429	T	Reconstruction, knee	254	34.37	$1,817.86	$937.22	$363.57
27430	T	Revision of thigh muscles	253	26.33	$1,392.78	$699.24	$278.56
27435	T	Incision of knee joint	253	26.33	$1,392.78	$699.24	$278.56
27437	T	Revise kneecap	217	20.48	$1,083.27	$526.81	$216.65
27438	T	Revise kneecap with implant	218	27.50	$1,454.49	$715.52	$290.90
27440	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27441	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27442	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27443	T	Revision of knee joint	217	20.48	$1,083.27	$526.81	$216.65
27445	C	Revision of knee joint	.....	.....	.....	.....	.....
27446	C	Revision of knee joint	.....	.....	.....	.....	.....
27447	C	Total knee replacement	.....	.....	.....	.....	.....
27448	C	Incision of thigh	.....	.....	.....	.....	.....
27450	C	Incision of thigh	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27454	C	Realignment of thigh bone					
27455	C	Realignment of knee					
27457	C	Realignment of knee					
27465	C	Shortening of thigh bone					
27466	C	Lengthening of thigh bone					
27468	C	Shorten/lengthen thighs					
27470	C	Repair of thigh					
27472	C	Repair/graft of thigh					
27475	C	Surgery to stop leg growth					
27477	C	Surgery to stop leg growth					
27479	C	Surgery to stop leg growth					
27485	C	Surgery to stop leg growth					
27486	C	Revise knee joint replace					
27487	C	Revise knee joint replace					
27488	C	Removal of knee prosthesis					
27495	C	Reinforce thigh					
27496	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27497	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27498	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27499	T	Decompression of thigh/knee	251	14.26	$754.18	$366.12	$150.84
27500	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27501	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27502	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27503	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27506	C	Repair of thigh fracture					
27507	C	Treatment of thigh fracture					
27508	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27509	T	Treatment of thigh fracture	216	20.13	$1,064.67	$520.93	$212.93
27510	T	Treatment of thigh fracture	209	1.94	$102.84	$37.29	$20.57
27511	C	Treatment of thigh fracture					
27513	C	Treatment of thigh fracture					
27514	C	Repair of thigh fracture					
27516	T	Repair of thigh growth plate	209	1.94	$102.84	$37.29	$20.57
27517	T	Repair of thigh growth plate	209	1.94	$102.84	$37.29	$20.57
27519	C	Repair of thigh growth plate					
27520	T	Treat kneecap fracture	209	1.94	$102.84	$37.29	$20.57
27524	C	Repair of kneecap fracture					
27530	T	Treatment of knee fracture	209	1.94	$102.84	$37.29	$20.57
27532	T	Treatment of knee fracture	209	1.94	$102.84	$37.29	$20.57
27535	C	Treatment of knee fracture					
27536	C	Repair of knee fracture					
27538	T	Treat knee fracture(s)	209	1.94	$102.84	$37.29	$20.57
27540	C	Repair of knee fracture					
27550	T	Treat knee dislocation	209	1.94	$102.84	$37.29	$20.57
27552	T	Treat knee dislocation	210	10.46	$553.39	$283.40	$110.68
27556	T	Repair of knee dislocation	216	20.13	$1,064.67	$520.93	$212.93
27557	C	Repair of knee dislocation					
27558	C	Repair of knee dislocation					
27560	T	Treat kneecap dislocation	209	1.94	$102.84	$37.29	$20.57
27562	T	Treat kneecap dislocation	210	10.46	$553.39	$283.40	$110.68
27566	T	Repair kneecap dislocation	216	20.13	$1,064.67	$520.93	$212.93
27570	T	Fixation of knee joint	210	10.46	$553.39	$283.40	$110.68
27580	C	Fusion of knee					
27590	C	Amputate leg at thigh					
27591	C	Amputate leg at thigh					
27592	C	Amputate leg at thigh					
27594	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
27596	C	Amputation follow-up surgery					
27598	C	Amputate lower leg at knee					
27599	T	Leg surgery procedure	209	1.94	$102.84	$37.29	$20.57
27600	T	Decompression of lower leg	251	14.26	$754.18	$366.12	$150.84
27601	T	Decompression of lower leg	251	14.26	$754.18	$366.12	$150.84
27602	T	Decompression of lower leg	251	14.26	$754.18	$366.12	$150.84
27603	T	Drain lower leg lesion	132	6.04	$319.3	$134.24	$63.86
27604	T	Drain lower leg bursa	251	14.26	$754.18	$366.12	$150.84
27605	T	Incision of achilles tendon	271	14.41	$762.01	$368.38	$152.40
27606	T	Incision of achilles tendon	251	14.26	$754.18	$366.12	$150.84
27607	T	Treat lower leg bone lesion	251	14.26	$754.18	$366.12	$150.84
27610	T	Explore/treat ankle joint	252	19.39	$1,025.49	$509.18	$205.10
27612	T	Exploration of ankle joint	252	19.39	$1,025.49	$509.18	$205.10
27613	T	Biopsy lower leg soft tissue	161	3.50	$185.12	$75.48	$37.02
27614	T	Biopsy lower leg soft tissue	163	10.69	$565.14	$264.65	$113.03
27615	T	Remove tumor, lower leg	216	20.13	$1,064.67	$520.93	$212.93
27618	T	Remove lower leg lesion	163	10.69	$565.14	$264.65	$113.03
27619	T	Remove lower leg lesion	163	10.69	$565.14	$264.65	$113.03

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27620	T	Explore, treat ankle joint	252	19.39	$1,025.49	$509.18	$205.10
27625	T	Remove ankle joint lining	252	19.39	$1,025.49	$509.18	$205.10
27626	T	Remove ankle joint lining	252	19.39	$1,025.49	$509.18	$205.10
27630	T	Removal of tendon lesion	251	14.26	$754.18	$366.12	$150.84
27635	T	Remove lower leg bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27637	T	Remove/graft leg bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27638	T	Remove/graft leg bone lesion	252	19.39	$1,025.49	$509.18	$205.10
27640	T	Partial removal of tibia	253	26.33	$1,392.78	$699.24	$278.56
27641	T	Partial removal of fibula	252	19.39	$1,025.49	$509.18	$205.10
27645	C	Extensive lower leg surgery					
27646	C	Extensive lower leg surgery					
27647	T	Extensive ankle/heel surgery	253	26.33	$1,392.78	$699.24	$278.56
27648	T	Injection for ankle x-ray	347	2.93	$154.75	$62.15	$30.95
27650	T	Repair achilles tendon	253	26.33	$1,392.78	$699.24	$278.56
27652	T	Repair/graft achilles tendon	253	26.33	$1,392.78	$699.24	$278.56
27654	T	Repair of achilles tendon	253	26.33	$1,392.78	$699.24	$278.56
27656	T	Repair leg fascia defect	251	14.26	$754.18	$366.12	$150.84
27658	T	Repair of leg tendon, each	251	14.26	$754.18	$366.12	$150.84
27659	T	Repair of leg tendon, each	251	14.26	$754.18	$366.12	$150.84
27664	T	Repair of leg tendon, each	251	14.26	$754.18	$366.12	$150.84
27665	T	Repair of leg tendon, each	252	19.39	$1,025.49	$509.18	$205.10
27675	T	Repair lower leg tendons	251	14.26	$754.18	$366.12	$150.84
27676	T	Repair lower leg tendons	252	19.39	$1,025.49	$509.18	$205.10
27680	T	Release of lower leg tendon	252	19.39	$1,025.49	$509.18	$205.10
27681	T	Release of lower leg tendons	252	19.39	$1,025.49	$509.18	$205.10
27685	T	Revision of lower leg tendon	252	19.39	$1,025.49	$509.18	$205.10
27686	T	Revise lower leg tendons	252	19.39	$1,025.49	$509.18	$205.10
27687	T	Revision of calf tendon	252	19.39	$1,025.49	$509.18	$205.10
27690	T	Revise lower leg tendon	253	26.33	$1,392.78	$699.24	$278.56
27691	T	Revise lower leg tendon	253	26.33	$1,392.78	$699.24	$278.56
27692	T	Revise additional leg tendon	253	26.33	$1,392.78	$699.24	$278.56
27695	T	Repair of ankle ligament	252	19.39	$1,025.49	$509.18	$205.10
27696	T	Repair of ankle ligaments	252	19.39	$1,025.49	$509.18	$205.10
27698	T	Repair of ankle ligament	252	19.39	$1,025.49	$509.18	$205.10
27700	T	Revision of ankle joint	217	20.48	$1,083.27	$526.81	$216.65
27702	C	Reconstruct ankle joint					
27703	C	Reconstruction, ankle joint					
27704	T	Removal of ankle implant	251	14.26	$754.18	$366.12	$150.84
27705	T	Incision of tibia	253	26.33	$1,392.78	$699.24	$278.56
27707	T	Incision of fibula	251	14.26	$754.18	$366.12	$150.84
27709	T	Incision of tibia & fibula	252	19.39	$1,025.49	$509.18	$205.10
27712	C	Realignment of lower leg					
27715	C	Revision of lower leg					
27720	C	Repair of tibia					
27722	C	Repair/graft of tibia					
27724	C	Repair/graft of tibia					
27725	C	Repair of lower leg					
27727	C	Repair of lower leg					
27730	T	Repair of tibia epiphysis	252	19.39	$1,025.49	$509.18	$205.10
27732	T	Repair of fibula epiphysis	252	19.39	$1,025.49	$509.18	$205.10
27734	T	Repair lower leg epiphyses	252	19.39	$1,025.49	$509.18	$205.10
27740	T	Repair of leg epiphyses	252	19.39	$1,025.49	$509.18	$205.10
27742	T	Repair of leg epiphyses	253	26.33	$1,392.78	$699.24	$278.56
27745	T	Reinforce tibia	253	26.33	$1,392.78	$699.24	$278.56
27750	T	Treatment of tibia fracture	209	1.94	$102.84	$37.29	$20.57
27752	T	Treatment of tibia fracture	209	1.94	$102.84	$37.29	$20.57
27756	T	Repair of tibia fracture	216	20.13	$1,064.67	$520.93	$212.93
27758	T	Repair of tibia fracture	216	20.13	$1,064.67	$520.93	$212.93
27759	T	Repair of tibia fracture	216	20.13	$1,064.67	$520.93	$212.93
27760	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27762	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27766	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27780	T	Treatment of fibula fracture	209	1.94	$102.84	$37.29	$20.57
27781	T	Treatment of fibula fracture	209	1.94	$102.84	$37.29	$20.57
27784	T	Repair of fibula fracture	216	20.13	$1,064.67	$520.93	$212.93
27786	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27788	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27792	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27808	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27810	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27814	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27816	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27818	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
27822	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
27823	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
27824	T	Treat lower leg fracture	209	1.94	$102.84	$37.29	$20.57
27825	T	Treat lower leg fracture	209	1.94	$102.84	$37.29	$20.57
27826	T	Treat lower leg fracture	216	20.13	$1,064.67	$520.93	$212.93
27827	T	Treat lower leg fracture	216	20.13	$1,064.67	$520.93	$212.93
27828	T	Treat lower leg fracture	216	20.13	$1,064.67	$520.93	$212.93
27829	T	Treat lower leg joint	216	20.13	$1,064.67	$520.93	$212.93
27830	T	Treat lower leg dislocation	209	1.94	$102.84	$37.29	$20.57
27831	T	Treat lower leg dislocation	210	10.46	$553.39	$283.40	$110.68
27832	T	Repair lower leg dislocation	216	20.13	$1,064.67	$520.93	$212.93
27840	T	Treat ankle dislocation	209	1.94	$102.84	$37.29	$20.57
27842	T	Treat ankle dislocation	210	10.46	$553.39	$283.40	$110.68
27846	T	Repair ankle dislocation	216	20.13	$1,064.67	$520.93	$212.93
27848	T	Repair ankle dislocation	216	20.13	$1,064.67	$520.93	$212.93
27860	T	Fixation of ankle joint	210	10.46	$553.39	$283.40	$110.68
27870	T	Fusion of ankle joint	253	26.33	$1,392.78	$699.24	$278.56
27871	T	Fusion of tibiofibular joint	253	26.33	$1,392.78	$699.24	$278.56
27880	C	Amputation of lower leg	.....	.....	.....	.....	.....
27881	C	Amputation of lower leg	.....	.....	.....	.....	.....
27882	C	Amputation of lower leg	.....	.....	.....	.....	.....
27884	T	Amputation follow-up surgery	251	14.26	$754.18	$366.12	$150.84
27886	C	Amputation follow-up surgery	.....	.....	.....	.....	.....
27888	C	Amputation of foot at ankle	.....	.....	.....	.....	.....
27889	T	Amputation of foot at ankle	252	19.39	$1,025.49	$509.18	$205.10
27892	T	Decompression of leg	251	14.26	$754.18	$366.12	$150.84
27893	T	Decompression of leg	251	14.26	$754.18	$366.12	$150.84
27894	T	Decompression of leg	251	14.26	$754.18	$366.12	$150.84
27899	T	Leg/ankle surgery procedure	209	1.94	$102.84	$37.29	$20.57
28001	T	Drainage of bursa of foot	132	6.04	$319.3	$134.24	$63.86
28002	T	Treatment of foot infection	251	14.26	$754.18	$366.12	$150.84
28003	T	Treatment of foot infection	251	14.26	$754.18	$366.12	$150.84
28005	T	Treat foot bone lesion	271	14.41	$762.01	$368.38	$152.40
28008	T	Incision of foot fascia	271	14.41	$762.01	$368.38	$152.40
28010	T	Incision of toe tendon	271	14.41	$762.01	$368.38	$152.40
28011	T	Incision of toe tendons	271	14.41	$762.01	$368.38	$152.40
28020	T	Exploration of a foot joint	271	14.41	$762.01	$368.38	$152.40
28022	T	Exploration of a foot joint	271	14.41	$762.01	$368.38	$152.40
28024	T	Exploration of a toe joint	271	14.41	$762.01	$368.38	$152.40
28030	T	Removal of foot nerve	631	12.98	$686.60	$333.80	$137.32
28035	T	Decompression of tibia nerve	631	12.98	$686.60	$333.80	$137.32
28043	T	Excision of foot lesion	162	5.67	$299.71	$125.43	$59.94
28045	T	Excision of foot lesion	271	14.41	$762.01	$368.38	$152.40
28046	T	Resection of tumor, foot	271	14.41	$762.01	$368.38	$152.40
28050	T	Biopsy of foot joint lining	271	14.41	$762.01	$368.38	$152.40
28052	T	Biopsy of foot joint lining	271	14.41	$762.01	$368.38	$152.40
28054	T	Biopsy of toe joint lining	271	14.41	$762.01	$368.38	$152.40
28060	T	Partial removal foot fascia	272	16.56	$875.63	$409.74	$175.13
28062	T	Removal of foot fascia	272	16.56	$875.63	$409.74	$175.13
28070	T	Removal of foot joint lining	272	16.56	$875.63	$409.74	$175.13
28072	T	Removal of foot joint lining	272	16.56	$875.63	$409.74	$175.13
28080	T	Removal of foot lesion	271	14.41	$762.01	$368.38	$152.40
28086	T	Excise foot tendon sheath	271	14.41	$762.01	$368.38	$152.40
28088	T	Excise foot tendon sheath	271	14.41	$762.01	$368.38	$152.40
28090	T	Removal of foot lesion	271	14.41	$762.01	$368.38	$152.40
28092	T	Removal of toe lesions	271	14.41	$762.01	$368.38	$152.40
28100	T	Removal of ankle/heel lesion	271	14.41	$762.01	$368.38	$152.40
28102	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28103	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28104	T	Removal of foot lesion	271	14.41	$762.01	$368.38	$152.40
28106	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28107	T	Remove/graft foot lesion	272	16.56	$875.63	$409.74	$175.13
28108	T	Removal of toe lesions	271	14.41	$762.01	$368.38	$152.40
28110	T	Part removal of metatarsal	276	19.19	$1,014.71	$500.14	$202.94
28111	T	Part removal of metatarsal	271	14.41	$762.01	$368.38	$152.40
28112	T	Part removal of metatarsal	271	14.41	$762.01	$368.38	$152.40
28113	T	Part removal of metatarsal	271	14.41	$762.01	$368.38	$152.40
28114	T	Removal of metatarsal heads	271	14.41	$762.01	$368.38	$152.40
28116	T	Revision of foot	271	14.41	$762.01	$368.38	$152.40
28118	T	Removal of heel bone	271	14.41	$762.01	$368.38	$152.40
28119	T	Removal of heel spur	271	14.41	$762.01	$368.38	$152.40
28120	T	Part removal of ankle/heel	271	14.41	$762.01	$368.38	$152.40
28122	T	Partial removal of foot bone	271	14.41	$762.01	$368.38	$152.40
28124	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28126	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28130	T	Removal of ankle bone	271	14.41	$762.01	$368.38	$152.40
28140	T	Removal of metatarsal	271	14.41	$762.01	$368.38	$152.40

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
28150	T	Removal of toe	271	14.41	$762.01	$368.38	$152.40
28153	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28160	T	Partial removal of toe	271	14.41	$762.01	$368.38	$152.40
28171	T	Extensive foot surgery	271	14.41	$762.01	$368.38	$152.40
28173	T	Extensive foot surgery	271	14.41	$762.01	$368.38	$152.40
28175	T	Extensive foot surgery	271	14.41	$762.01	$368.38	$152.40
28190	T	Removal of foot foreign body	161	3.50	$185.12	$75.48	$37.02
28192	T	Removal of foot foreign body	163	10.69	$565.14	$264.65	$113.03
28193	T	Removal of foot foreign body	163	10.69	$565.14	$264.65	$113.03
28200	T	Repair of foot tendon	271	14.41	$762.01	$368.38	$152.40
28202	T	Repair/graft of foot tendon	272	16.56	$875.63	$409.74	$175.13
28208	T	Repair of foot tendon	271	14.41	$762.01	$368.38	$152.40
28210	T	Repair/graft of foot tendon	271	14.41	$762.01	$368.38	$152.40
28220	T	Release of foot tendon	271	14.41	$762.01	$368.38	$152.40
28222	T	Release of foot tendons	271	14.41	$762.01	$368.38	$152.40
28225	T	Release of foot tendon	271	14.41	$762.01	$368.38	$152.40
28226	T	Release of foot tendons	271	14.41	$762.01	$368.38	$152.40
28230	T	Incision of foot tendon(s)	271	14.41	$762.01	$368.38	$152.40
28232	T	Incision of toe tendon	271	14.41	$762.01	$368.38	$152.40
28234	T	Incision of foot tendon	271	14.41	$762.01	$368.38	$152.40
28238	T	Revision of foot tendon	272	16.56	$875.63	$409.74	$175.13
28240	T	Release of big toe	271	14.41	$762.01	$368.38	$152.40
28250	T	Revision of foot fascia	272	16.56	$875.63	$409.74	$175.13
28260	T	Release of midfoot joint	272	16.56	$875.63	$409.74	$175.13
28261	T	Revision of foot tendon	272	16.56	$875.63	$409.74	$175.13
28262	T	Revision of foot and ankle	272	16.56	$875.63	$409.74	$175.13
28264	T	Release of midfoot joint	272	16.56	$875.63	$409.74	$175.13
28270	T	Release of foot contracture	271	14.41	$762.01	$368.38	$152.40
28272	T	Release of toe joint, each	271	14.41	$762.01	$368.38	$152.40
28280	T	Fusion of toes	271	14.41	$762.01	$368.38	$152.40
28285	T	Repair of hammertoe	271	14.41	$762.01	$368.38	$152.40
28286	T	Repair of hammertoe	271	14.41	$762.01	$368.38	$152.40
28288	T	Partial removal of foot bone	272	16.56	$875.63	$409.74	$175.13
28290	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28292	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28293	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28294	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28296	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28297	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28298	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28299	T	Correction of bunion	276	19.19	$1,014.71	$500.14	$202.94
28300	T	Incision of heel bone	272	16.56	$875.63	$409.74	$175.13
28302	T	Incision of ankle bone	272	16.56	$875.63	$409.74	$175.13
28304	T	Incision of midfoot bones	272	16.56	$875.63	$409.74	$175.13
28305	T	Incise/graft midfoot bones	272	16.56	$875.63	$409.74	$175.13
28306	T	Incision of metatarsal	272	16.56	$875.63	$409.74	$175.13
28307	T	Incision of metatarsal	272	16.56	$875.63	$409.74	$175.13
28308	T	Incision of metatarsal	272	16.56	$875.63	$409.74	$175.13
28309	T	Incision of metatarsals	272	16.56	$875.63	$409.74	$175.13
28310	T	Revision of big toe	271	14.41	$762.01	$368.38	$152.40
28312	T	Revision of toe	271	14.41	$762.01	$368.38	$152.40
28313	T	Repair deformity of toe	271	14.41	$762.01	$368.38	$152.40
28315	T	Removal of sesamoid bone	271	14.41	$762.01	$368.38	$152.40
28320	T	Repair of foot bones	272	16.56	$875.63	$409.74	$175.13
28322	T	Repair of metatarsals	272	16.56	$875.63	$409.74	$175.13
28340	T	Resect enlarged toe tissue	271	14.41	$762.01	$368.38	$152.40
28341	T	Resect enlarged toe	271	14.41	$762.01	$368.38	$152.40
28344	T	Repair extra toe(s)	272	16.56	$875.63	$409.74	$175.13
28345	T	Repair webbed toe(s)	272	16.56	$875.63	$409.74	$175.13
28360	T	Reconstruct cleft foot	272	16.56	$875.63	$409.74	$175.13
28400	T	Treatment of heel fracture	209	1.94	$102.84	$37.29	$20.57
28405	T	Treatment of heel fracture	209	1.94	$102.84	$37.29	$20.57
28406	T	Treatment of heel fracture	216	20.13	$1,064.67	$520.93	$212.93
28415	T	Repair of heel fracture	216	20.13	$1,064.67	$520.93	$212.93
28420	T	Repair/graft heel fracture	216	20.13	$1,064.67	$520.93	$212.93
28430	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
28435	T	Treatment of ankle fracture	209	1.94	$102.84	$37.29	$20.57
28436	T	Treatment of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
28445	T	Repair of ankle fracture	216	20.13	$1,064.67	$520.93	$212.93
28450	T	Treat midfoot fracture, each	209	1.94	$102.84	$37.29	$20.57
28455	T	Treat midfoot fracture, each	209	1.94	$102.84	$37.29	$20.57
28456	T	Repair midfoot fracture	216	20.13	$1,064.67	$520.93	$212.93
28465	T	Repair midfoot fracture, each	216	20.13	$1,064.67	$520.93	$212.93
28470	T	Treat metatarsal fracture	209	1.94	$102.84	$37.29	$20.57
28475	T	Treat metatarsal fracture	209	1.94	$102.84	$37.29	$20.57

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
28476	T	Repair metatarsal fracture	216	20.13	$1,064.67	$520.93	$212.93
28485	T	Repair metatarsal fracture	216	20.13	$1,064.67	$520.93	$212.93
28490	T	Treat big toe fracture	207	1.70	$90.11	$31.64	$18.02
28495	T	Treat big toe fracture	207	1.70	$90.11	$31.64	$18.02
28496	T	Repair big toe fracture	216	20.13	$1,064.67	$520.93	$212.93
28505	T	Repair big toe fracture	216	20.13	$1,064.67	$520.93	$212.93
28510	T	Treatment of toe fracture	207	1.70	$90.11	$31.64	$18.02
28515	T	Treatment of toe fracture	207	1.70	$90.11	$31.64	$18.02
28525	T	Repair of toe fracture	216	20.13	$1,064.67	$520.93	$212.93
28530	T	Treat sesamoid bone fracture	209	1.94	$102.84	$37.29	$20.57
28531	T	Treat sesamoid bone fracture	216	20.13	$1,064.67	$520.93	$212.93
28540	T	Treat foot dislocation	209	1.94	$102.84	$37.29	$20.57
28545	T	Treat foot dislocation	210	10.46	$553.39	$283.40	$110.68
28546	T	Treat foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28555	T	Repair foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28570	T	Treat foot dislocation	209	1.94	$102.84	$37.29	$20.57
28575	T	Treat foot dislocation	210	10.46	$553.39	$283.40	$110.68
28576	T	Treat foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28585	T	Repair foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28600	T	Treat foot dislocation	209	1.94	$102.84	$37.29	$20.57
28605	T	Treat foot dislocation	210	10.46	$553.39	$283.40	$110.68
28606	T	Treat foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28615	T	Repair foot dislocation	216	20.13	$1,064.67	$520.93	$212.93
28630	T	Treat toe dislocation	207	1.70	$90.11	$31.64	$18.02
28635	T	Treat toe dislocation	210	10.46	$553.39	$283.40	$110.68
28636	T	Treat toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28645	T	Repair toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28660	T	Treat toe dislocation	207	1.70	$90.11	$31.64	$18.02
28665	T	Treat toe dislocation	210	10.46	$553.39	$283.40	$110.68
28666	T	Treat toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28675	T	Repair of toe dislocation	216	20.13	$1,064.67	$520.93	$212.93
28705	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28715	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28725	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28730	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28735	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28737	T	Revision of foot bones	271	14.41	$762.01	$368.38	$152.40
28740	T	Fusion of foot bones	272	16.56	$875.63	$409.74	$175.13
28750	T	Fusion of big toe joint	271	14.41	$762.01	$368.38	$152.40
28755	T	Fusion of big toe joint	271	14.41	$762.01	$368.38	$152.40
28760	T	Fusion of big toe joint	272	16.56	$875.63	$409.74	$175.13
28800	C	Amputation of midfoot					
28805	C	Amputation thru metatarsal					
28810	T	Amputation toe & metatarsal	271	14.41	$762.01	$368.38	$152.40
28820	T	Amputation of toe	271	14.41	$762.01	$368.38	$152.40
28825	T	Partial amputation of toe	271	14.41	$762.01	$368.38	$152.40
28899	T	Foot/toes surgery procedure	207	1.70	$90.11	$31.64	$18.02
29000	N	Application of body cast					
29010	N	Application of body cast					
29015	N	Application of body cast					
29020	N	Application of body cast					
29025	N	Application of body cast					
29035	N	Application of body cast					
29040	N	Application of body cast					
29044	N	Application of body cast					
29046	N	Application of body cast					
29049	N	Application of figure eight					
29055	N	Application of shoulder cast					
29058	N	Application of shoulder cast					
29065	N	Application of long arm cast					
29075	N	Application of forearm cast					
29085	N	Apply hand/wrist cast					
29105	N	Apply long arm splint					
29125	N	Apply forearm splint					
29126	N	Apply forearm splint					
29130	N	Application of finger splint					
29131	N	Application of finger splint					
29200	N	Strapping of chest					
29220	N	Strapping of low back					
29240	N	Strapping of shoulder					
29260	N	Strapping of elbow or wrist					
29280	N	Strapping of hand or finger					
29305	N	Application of hip cast					
29325	N	Application of hip casts					
29345	N	Application of long leg cast					

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
29355	N	Application of long leg cast	.....	.....	.....	.....	.....
29358	N	Apply long leg cast brace	.....	.....	.....	.....	.....
29365	N	Application of long leg cast	.....	.....	.....	.....	.....
29405	N	Apply short leg cast	.....	.....	.....	.....	.....
29425	N	Apply short leg cast	.....	.....	.....	.....	.....
29435	N	Apply short leg cast	.....	.....	.....	.....	.....
29440	N	Addition of walker to cast	.....	.....	.....	.....	.....
29445	N	Apply rigid leg cast	.....	.....	.....	.....	.....
29450	N	Application of leg cast	.....	.....	.....	.....	.....
29505	N	Application long leg splint	.....	.....	.....	.....	.....
29515	N	Application lower leg splint	.....	.....	.....	.....	.....
29520	N	Strapping of hip	.....	.....	.....	.....	.....
29530	N	Strapping of knee	.....	.....	.....	.....	.....
29540	N	Strapping of ankle	.....	.....	.....	.....	.....
29550	N	Strapping of toes	.....	.....	.....	.....	.....
29580	N	Application of paste boot	.....	.....	.....	.....	.....
29590	N	Application of foot splint	.....	.....	.....	.....	.....
29700	N	Removal/revision of cast	.....	.....	.....	.....	.....
29705	N	Removal/revision of cast	.....	.....	.....	.....	.....
29710	N	Removal/revision of cast	.....	.....	.....	.....	.....
29715	N	Removal/revision of cast	.....	.....	.....	.....	.....
29720	N	Repair of body cast	.....	.....	.....	.....	.....
29730	N	Windowing of cast	.....	.....	.....	.....	.....
29740	N	Wedging of cast	.....	.....	.....	.....	.....
29750	N	Wedging of clubfoot cast	.....	.....	.....	.....	.....
29799	N	Casting/strapping procedure	.....	.....	.....	.....	.....
29800	T	Jaw arthroscopy/surgery	280	22.20	$1,174.36	$581.72	$234.87
29804	T	Jaw arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29815	T	Shoulder arthroscopy	280	22.20	$1,174.36	$581.72	$234.87
29819	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29820	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29821	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29822	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29823	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29825	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29826	T	Shoulder arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29830	T	Elbow arthroscopy	280	22.20	$1,174.36	$581.72	$234.87
29834	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29835	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29836	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29837	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29838	T	Elbow arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29840	T	Wrist arthroscopy	280	22.20	$1,174.36	$581.72	$234.87
29843	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29844	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29845	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29846	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29847	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29848	T	Wrist arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29850	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29851	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29855	T	Tibial arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29856	T	Tibial arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29860	T	Hip arthroscopy, dx	281	22.65	$1,197.87	$590.31	$239.57
29861	T	Hip arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29862	T	Hip arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29863	T	Hip arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29870	T	Knee arthroscopy, diagnostic	280	22.20	$1,174.36	$581.72	$234.87
29871	T	Knee arthroscopy/drainage	282	23.94	$1,266.43	$614.04	$253.29
29874	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29875	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29876	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29877	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29879	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29880	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29881	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29882	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29883	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29884	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29885	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29886	T	Knee arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29887	T	Knee arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29
29888	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29889	T	Knee arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29891	T	Ankle arthroscopy/surgery	282	23.94	$1,266.43	$614.04	$253.29

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
29892	T	Ankle arthroscopy/surgery	286	26.76	$1,415.31	$802.53	$283.06
29893	T	Scope, plantar fasciotomy	271	14.41	$762.01	$368.38	$152.40
29894	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29895	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29897	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29898	T	Ankle arthroscopy/surgery	281	22.65	$1,197.87	$590.31	$239.57
29909	T	Arthroscopy of joint	280	22.20	$1,174.36	$581.72	$234.87
30000	T	Drainage of nose lesion	311	1.43	$75.42	$20.57	$15.08
30020	T	Drainage of nose lesion	311	1.43	$75.42	$20.57	$15.08
30100	T	Intranasal biopsy	311	1.43	$75.42	$20.57	$15.08
30110	T	Removal of nose polyp(s)	311	1.43	$75.42	$20.57	$15.08
30115	T	Removal of nose polyp(s)	313	15.81	$836.45	$411.09	$167.29
30117	T	Removal of intranasal lesion	311	1.43	$75.42	$20.57	$15.08
30118	T	Removal of intranasal lesion	313	15.81	$836.45	$411.09	$167.29
30120	T	Revision of nose	313	15.81	$836.45	$411.09	$167.29
30124	T	Removal of nose lesion	311	1.43	$75.42	$20.57	$15.08
30125	T	Removal of nose lesion	313	15.81	$836.45	$411.09	$167.29
30130	T	Removal of turbinate bones	313	15.81	$836.45	$411.09	$167.29
30140	T	Removal of turbinate bones	313	15.81	$836.45	$411.09	$167.29
30150	T	Partial removal of nose	313	15.81	$836.45	$411.09	$167.29
30160	T	Removal of nose	313	15.81	$836.45	$411.09	$167.29
30200	T	Injection treatment of nose	347	2.93	$154.75	$62.15	$30.95
30210	T	Nasal sinus therapy	311	1.43	$75.42	$20.57	$15.08
30220	T	Insert nasal septal button	311	1.43	$75.42	$20.57	$15.08
30300	T	Remove nasal foreign body	311	1.43	$75.42	$20.57	$15.08
30310	T	Remove nasal foreign body	313	15.81	$836.45	$411.09	$167.29
30320	T	Remove nasal foreign body	313	15.81	$836.45	$411.09	$167.29
30400	T	Reconstruction of nose	314	25.65	$1,356.54	$693.37	$271.31
30410	T	Reconstruction of nose	314	25.65	$1,356.54	$693.37	$271.31
30420	T	Reconstruction of nose	314	25.65	$1,356.54	$693.37	$271.31
30430	T	Revision of nose	313	15.81	$836.45	$411.09	$167.29
30435	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30450	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30460	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30462	T	Revision of nose	314	25.65	$1,356.54	$693.37	$271.31
30520	T	Repair of nasal septum	313	15.81	$836.45	$411.09	$167.29
30540	T	Repair nasal defect	313	15.81	$836.45	$411.09	$167.29
30545	T	Repair nasal defect	314	25.65	$1,356.54	$693.37	$271.31
30560	T	Release of nasal adhesions	311	1.43	$75.42	$20.57	$15.08
30580	T	Repair upper jaw fistula	313	15.81	$836.45	$411.09	$167.29
30600	T	Repair mouth/nose fistula	313	15.81	$836.45	$411.09	$167.29
30620	T	Intranasal reconstruction	313	15.81	$836.45	$411.09	$167.29
30630	T	Repair nasal septum defect	313	15.81	$836.45	$411.09	$167.29
30801	T	Cauterization inner nose	312	7.26	$383.95	$178.31	$76.79
30802	T	Cauterization inner nose	312	7.26	$383.95	$178.31	$76.79
30901	T	Control of nosebleed	318	2.07	$109.70	$38.65	$21.94
30903	T	Control of nosebleed	318	2.07	109.70	$38.65	$21.94
30905	T	Control of nosebleed	318	2.07	$109.70	$38.65	$21.94
30906	T	Repeat control of nosebleed	318	2.07	$109.70	$38.65	$21.94
30915	T	Ligation nasal sinus artery	367	17.59	$930.48	$449.06	$186.10
30920	T	Ligation upper jaw artery	367	17.59	$930.48	$449.06	$186.10
30930	T	Therapy fracture of nose	312	7.26	$383.95	$178.31	$76.79
30999	T	Nasal surgery procedure	318	2.07	$109.70	$38.65	$21.94
31000	T	Irrigation maxillary sinus	311	1.43	$75.42	$20.57	$15.08
31002	T	Irrigation sphenoid sinus	311	1.43	$75.42	$20.57	$15.08
31020	T	Exploration maxillary sinus	313	15.81	$836.45	$411.09	$167.29
31030	T	Exploration maxillary sinus	313	15.81	$836.45	$411.09	$167.29
31032	T	Explore sinus, remove polyps	313	15.81	$836.45	$411.09	$167.29
31040	T	Exploration behind upper jaw	314	25.65	$1,356.54	$693.37	$271.31
31050	T	Exploration sphenoid sinus	313	15.81	$836.45	$411.09	$167.29
31051	T	Sphenoid sinus surgery	313	15.81	$836.45	$411.09	$167.29
31070	T	Exploration of frontal sinus	313	15.81	$836.45	$411.09	$167.29
31075	T	Exploration of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31080	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31081	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31084	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31085	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31086	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31087	T	Removal of frontal sinus	314	25.65	$1,356.54	$693.37	$271.31
31090	T	Exploration of sinuses	314	25.65	$1,356.54	$693.37	$271.31
31200	T	Removal of ethmoid sinus	313	15.81	$836.45	$411.09	$167.29
31201	T	Removal of ethmoid sinus	314	25.65	$1,356.54	$693.37	$271.31
31205	T	Removal of ethmoid sinus	314	25.65	$1,356.54	$693.37	$271.31
31225	C	Removal of upper jaw	.....	.....	.....	.....	.....
31230	C	Removal of upper jaw	.....	.....	.....	.....	.....

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ADDENDUM B.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	HOPD status indicator	Description	Proposed APC	Relative weight	Proposed payment rate	National unadjusted coinsurance	Minimum unadjusted coinsurance
31231	T	Nasal endoscopy, dx	331	0.69	$36.24	$14.01	$7.25
31233	T	Nasal/sinus endoscopy, dx	332	9.74	$515.19	$244.98	$103.04
31235	T	Nasal/sinus endoscopy, dx	332	9.74	$515.19	$244.98	$103.04
31237	T	Nasal/sinus endoscopy, surg	332	9.74	$515.19	$244.98	$103.04
31238	T	Nasal/sinus endoscopy, surg	332	9.74	$515.19	$244.98	$103.04
31239	T	Nasal/sinus endoscopy, surg	333	17.24	$911.87	$464.20	$182.37
31240	T	Nasal/sinus endoscopy, surg	332	9.74	$515.19	$244.98	$103.04
31254	T	Revision of ethmoid sinus	333	17.24	$911.87	$464.20	$182.37
31255	T	Removal of ethmoid sinus	333	17.24	$911.87	$464.20	$182.37
31256	T	Exploration maxillary sinus	333	17.24	$911.87	$464.20	$182.37
31267	T	Endoscopy, maxillary sinus	333	17.24	$911.87	$464.20	$182.37
31276	T	Sinus surgical endoscopy	333	17.24	$911.87	$464.20	$182.37
31287	T	Nasal/sinus endoscopy, surg	333	17.24	$911.87	$464.20	$182.37
31288	T	Nasal/sinus endoscopy, surg	333	17.24	$911.87	$464.20	$182.37
31290	C	Nasal/sinus endoscopy, surg					
31291	C	Nasal/sinus endoscopy, surg					
31292	C	Nasal/sinus endoscopy, surg					
31293	C	Nasal/sinus endoscopy, surg					
31294	C	Nasal/sinus endoscopy, surg					
31299	T	Sinus surgery procedure	331	0.69	$36.24	$14.01	$7.25
31300	T	Removal of larynx lesion	314	25.65	$1,356.54	$693.37	$271.31
31320	T	Diagnostic incision larynx	313	15.81	$836.45	$411.09	$167.29
31360	C	Removal of larynx					
31365	C	Removal of larynx					
31367	C	Partial removal of larynx					
31368	C	Partial removal of larynx					
31370	C	Partial removal of larynx					
31375	C	Partial removal of larynx					
31380	C	Partial removal of larynx					
31382	C	Partial removal of larynx					
31390	C	Removal of larynx & pharynx					
31395	C	Reconstruct larynx & pharynx					
31400	T	Revision of larynx	314	25.65	$1,356.54	$693.37	$271.31
31420	T	Removal of epiglottis	314	25.65	$1,356.54	$693.37	$271.31
31500	S	Insert emergency airway	947	4.07	$215.48	$109.61	$43.10
31502	T	Change of windpipe airway	470	2.22	$117.53	$54.92	$23.51
31505	T	Diagnostic laryngoscopy	331	0.69	$36.24	$14.01	$7.25
31510	T	Laryngoscopy with biopsy	332	9.74	$515.19	$244.98	$103.04
31511	T	Remove foreign body, larynx	332	9.74	$515.19	$244.98	$103.04
31512	T	Removal of larynx lesion	332	9.74	$515.19	$244.98	$103.04
31513	T	Injection into vocal cord	332	9.74	$515.19	$244.98	$103.04
31515	T	Laryngoscopy for aspiration	332	9.74	$515.19	$244.98	$103.04
31520	T	Diagnostic laryngoscopy	332	9.74	$515.19	$244.98	$103.04
31525	T	Diagnostic laryngoscopy	332	9.74	$515.19	$244.98	$103.04
31526	T	Diagnostic laryngoscopy	332	9.74	$515.19	$244.98	$103.04
31527	T	Laryngoscopy for treatment	333	17.24	$911.87	$464.20	$182.37
31528	T	Laryngoscopy and dilatation	332	9.74	$515.19	$244.98	$103.04
31529	T	Laryngoscopy and dilatation	332	9.74	$515.19	$244.98	$103.04
31530	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31531	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31535	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31536	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31540	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31541	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31560	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31561	T	Operative laryngoscopy	333	17.24	$911.87	$464.20	$182.37
31570	T	Laryngoscopy with injection	333	17.24	$911.87	$464.20	$182.37
31571	T	Laryngoscopy with injection	333	17.24	$911.87	$464.20	$182.37
31575	T	Diagnostic laryngoscopy	331	0.69	$36.24	$14.01	$7.25
31576	T	Laryngoscopy with biopsy	332	9.74	$515.19	$244.98	$103.04
31577	T	Remove foreign body, larynx	332	9.74	$515.19	$244.98	$103.04
31578	T	Removal of larynx lesion	332	9.74	$515.19	$244.98	$103.04
31579	T	Diagnostic laryngoscopy	331	0.69	$36.24	$14.01	$7.25
31580	C	Revision of larynx					
31582	C	Revision of larynx					
31584	C	Repair of larynx fracture					
31585	T	Repair of larynx fracture	207	1.70	$90.11	$31.64	$18.02
31586	T	Repair of larynx fracture	209	1.94	$102.84	$37.29	$20.57
31587	C	Revision of larynx					
31588	T	Revision of larynx	314	25.65	$1,356.54	$693.37	$271.31
31590	T	Reinnervate larynx	314	25.65	$1,356.54	$693.37	$271.31
31595	T	Larynx nerve surgery	313	15.81	$836.45	$411.09	$167.29
31599	T	Larynx surgery procedure	207	1.70	$90.11	$31.64	$18.02
31600	C	Incision of windpipe					
31601	C	Incision of windpipe					

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